THE NATIONAL WIC EVALUATION

An Evaluation of the Special Supplemental Food Program
for Women, Infants and Children

VOLUME V: INSTRUMENTATION

TH NATIONAL EVALUATION

U.S. DEPARTMENT OF AGI
FOOD AND NUTRITION SE

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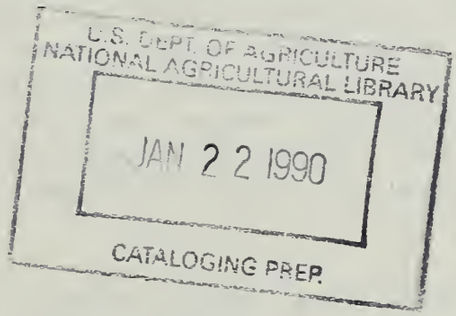
The National WIC Evaluation

An Evaluation of the Special Supplemental Food Program for Women, Infants, and Children

Volume V: Instrumentation

Appendixes to Chapter IV



Submitted to

Office of Analysis and Evaluation
Food and Nutrition Service
Department of Agriculture

Principal Investigator
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Prepared by

Research Triangle Institute
New York State Research Foundation for Mental Hygiene

Supported by Contract No. 53-3198-9-87

PREFACE

The evaluation of the Special Supplemental Food Program for Women, Infants and Children (WIC), designated here as the National WIC Evaluation, is a project undertaken by the Research Triangle Institute (RTI) under contract with the Office of Analysis and Evaluation, Food and Nutrition Service (FNS), United States Department of Agriculture (Contract No. 53-3198-9-87). The National WIC Evaluation is documented in this summary report and more comprehensively in four technical volumes: Volumes II and III - Technical Report and Volume IV and V - Appendixes. The summary report is written for the reader who wishes a brief nontechnical overview of the WIC program, an explanation of the logic of the National WIC Evaluation, and a discussion of its important results and conclusions. The technical report presents complete discussions of methodology, database construction, analysis techniques, results, and conclusions. The appendixes present copies of all data collection instruments used in the evaluation and supplementary tables referred to in the technical report.

This report covers the four component studies, namely the Historical Study of Pregnancy Outcomes, the Longitudinal Study of Pregnant Women, the Study of Infants and Children, and the Food Expenditures Study, upon which the National WIC Evaluation is based. These studies were designed primarily by the Principal Investigator, Dr. David Rush, with support from RTI staff and consultants, in the fall and winter of 1981-82. Dr. Rush's services, together with a small supporting staff, were made possible through a subcontract with the New York State Research Foundation for Mental Hygiene (NYRFMH).

Actual implementation of the studies began in the summer of 1982, with the major field data collection effort occurring during 1983. While RTI undertook major responsibility for organizing and managing the field effort, processing the data and preparing the basic data files, the entire effort was directed by Dr. Rush and carried out with support from his NYRFMH staff. The major analysis and reporting tasks were also carried out by Dr. Rush and his staff for three of the four component studies, with extensive support from RTI staff. The fourth study, concerned with food expenditures, was analyzed and the report prepared by RTI staff.

The success of the Historical Study was due in large part to the efforts of the State WIC program directors who, with their staff, provided annual counts of WIC women for individual clinics during the period 1974 to 1981. Considerable cooperation was also received from State directors of vital records who provided complete files of births and linked infant deaths for the period 1972 to 1980.

The Longitudinal Study, the Study of Children, and the Food Expenditures Study all acquired data through a national probability sample of pregnant women enrolled in the WIC program and a sample of low-income pregnant women not enrolled in WIC. The success of these samples and the success of the total data collection effort depended in no small part on the excellent cooperation of the directors and staff of the 174 WIC clinics and the directors and staff of the 55 non-WIC clinics that participated in the field phase of the study.

Both the study design and early drafts of this report were reviewed and critiqued by the FNS Advisory Panel to the National WIC Evaluation. The members of this Panel are listed on the inside cover.

The National WIC Evaluation received considerable support and valuable review and advice from the FNS Office of Analysis and Evaluation Project Officers Mr. David Shanklin and Dr. Burleigh Seaver. Particularly helpful were the review and comments of earlier drafts of this report by Dr. Seaver and by Ms. Nancy Chetry of the FNS Special Supplemental Food Division.

Finally, the consistently valuable, timely and able administration of the project by Ms. Sally Johnson is recognized.

D. G. Horvitz
Project Director

CONTENTS

APPENDIX IV-A: DATA COLLECTION INSTRUMENTS

OMB No. 0584-0306
Expires 12/31/83

CLINIC ADMINISTRATOR'S QUESTIONNAIRE

A Study of
Health and Nutrition of Mothers and Their Children

Sponsored by

Food and Nutrition Service
U.S. Department of Agriculture

Conducted by

New York State Research Foundation
and
Research Triangle Institute

ID LABEL

NOTICE: This study has been authorized by the U.S. Congress in its 1978 reauthorization of the WIC Program (Public Law 95-627). All information that would permit identification of an individual, facility, or state or local agency will be held in strict confidence, will be used only by persons engaged in and for the purposes of the survey, and will not be disclosed or released to others for any purposes.

1. Please describe the geographic area that your prenatal clinic serves. If complete counties are served, enter the county names in Column A. If partial counties or specified localities are served, enter the names of the cities, towns, or other jurisdictions in Column B.

If your clinic has no specifically or legally defined geographic service area, please check this box ☐ and go to Question 2.

A. COMPLETE COUNTIES	B. SPECIFIED LOCALITIES
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

2. What type of agency or organization sponsors this clinic?

(CIRCLE ONE.)

Neighborhood/community health agency. 01
Community action agency 02
Municipal health agency 03
County health agency. 04
State or district health agency 05
Indian health agency. 06
Public hospital 07
Private voluntary hospital. 08
Private proprietary hospital. 09
Other (PLEASE DESCRIBE) 10

_____

_____

3. Please list and define, in order of priority of importance, the criteria for serving pregnant women at your clinic. (Such criteria might include income level, third party coverage, obstetrical risk factors, etc.).

(1) _____

_____

_____

(2) _____

_____

_____

(3) _____

_____

_____

(4) _____

_____

_____

4. In an average month, about how many pregnant women register to begin services at this clinic?

_____ New pregnant patients

A. In an average month, about how many deliveries are reported for patients served by this clinic?

_____ Deliveries

5. Does this clinic serve Medicaid-eligible and/or low income patients?

(CIRCLE ONE.)

Yes 01
No. . . . . 02 (GO TO QUESTION 6.)

A. About how many <u>new</u> patients who are Medicaid-eligible and/or low income register for prenatal services at this clinic in an average month?

_____ New Medicaid/low-income patients

6. Is nutrition education or advice provided by this clinic?

(CIRCLE ONE.)

Yes 01
No. 02

7. Does this clinic routinely provide vitamin/mineral supplements to pregnant patients?

(CIRCLE ONE.)

Yes 01
No. . . . . 02 (GO TO QUESTION 8.)

A. Please describe the vitamin/mineral supplements offered by your clinic.

_____

_____

_____

8. Does this clinic provide food supplements to any pregnant patients, directly or through coupons, stamps, or commodity donations?

(CIRCLE ONE.)

Yes 01
No. . . . . 02 (GO TO QUESTION 9.)

A. Approximately what percentage of your pregnant patients receive food supplements?

_____ % of patients

B. Please describe the food supplements offered by your clinic.

_____

_____

_____

9. Are charges for any prenatal services based on a sliding-fee scale?

(CIRCLE ONE.)

Yes 01
No. . . . . 02 (GO TO QUESTION 10.)

A. What are the criteria for the sliding-fee scale?

(CIRCLE ALL THAT APPLY.)

Patient's ability to pay 01
Accept third party/Medicaid reimbursement. . 02
Other (PLEASE DESCRIBE). 03

_____

_____

10. In the table below, please provide the following information on your prenatal clinic's operating schedule.

- In Column A, circle the code for "YES" or "NO" to indicate if the prenatal clinic is open on each day of the week.
- In Column B, enter all times each day that the prenatal clinic is open for patient services. Always indicate "a.m." or "p.m." for times. (For example, 8:30 a.m. to 12:00 noon, 1:00 p.m. to 5:30 p.m., 7:00 p.m. to 9:00 p.m.)
- In Column C, please enter the particular times during which initial visits with <u>new</u> pregnant patients are scheduled each day that the clinic is open. If new pregnant patients are scheduled at any time during each day's operating hours, please check the "SAME" box.
- In Column D, please enter the particular times during which <u>follow-up prenatal visits</u> are scheduled. If follow-up visits are scheduled at any time during each day's operating hours, please check the "SAME" box.
- In Column E, circle the code that best describes the typical caseload of pregnant women on each day that the clinic is open.

DAY OF WEEK	A CLINIC OPEN?	B DAILY OPERATING HOURS	C HOURS FOR INITIAL PRENATAL VISITS	D HOURS FOR FOLLOW-UP PRENATAL VISITS	E TYPICAL CASELOAD OF PREGNANT PATIENTS
(1) Monday	Yes. . 01 No . . 02		☐ Same	☐ Same	Light . . 01 Moderate. 02 Heavy . . 03
(2) Tuesday	Yes. . 01 No . . 02		☐ Same	☐ Same	Light . . 01 Moderate. 02 Heavy . . 03
(3) Wednesday	Yes. . 01 No . . 02		☐ Same	☐ Same	Light . . 01 Moderate. 02 Heavy . . 03
(4) Thursday	Yes. . 01 No . . 02		☐ Same	☐ Same	Light . . 01 Moderate. 02 Heavy . . 03
(5) Friday	Yes. . 01 No . . 02		☐ Same	☐ Same	Light . . 01 Moderate. 02 Heavy . . 03
(6) Saturday	Yes. . 01 No . . 02		☐ Same	☐ Same	Light . . 01 Moderate. 02 Heavy . . 03
(7) Sunday	Yes. . 01 No . . 02		☐ Same	☐ Same	Light . . 01 Moderate. 02 Heavy . . 03

10. A. Does the schedule outlined in Columns A and B above vary at any time during the year?

(CIRCLE ONE.)

Yes 01
No . . . . . 02 (GO TO QUESTION 11.)

B. Please describe all variations in schedule.

_____

_____

_____

11. As part of this project, certain laboratory studies of anemic and normal pregnant women will be conducted. What procedure is <u>usually</u> used at your clinic for obtaining the first blood samples from pregnant women?

(CIRCLE ONE.)

Capillary sample (fingerstick) 01
Venipuncture . . . . . 02 (GO TO QUESTION 12.)
Neither. . . . . 03 (GO TO QUESTION 13.)

A. Are there facilities in your clinic for obtaining blood samples by venipuncture?

(CIRCLE ONE.)

Yes 01
No. . . . . 02 (GO TO QUESTION 12.)

B. If a hemoglobin or hematocrit value is low, is the capillary sample <u>routinely</u> followed by a venipuncture sample?

(CIRCLE ONE.)

Yes 01
No. 02

12. For new patients who are making their first clinic visit, when are the results for hemoglobin and hematocrit values from their first blood samples usually available?

(CIRCLE ONE.)

During visit. 01
Same day as visit 02
One or more days after visit
(PLEASE DESCRIBE) 03

_____

_____

13. Is there a beam balance scale for weighing adults in this clinic?

(CIRCLE ONE.)

Yes 01
No. 02

14. For each of the languages listed below, please enter the percentage of your total patients who speak the language as their principal language. (If exact percentages are not known, please provide your best estimate.)

LANGUAGE	PERCENT OF PATIENTS
(1) Chinese	%
(2) English	%
(3) French	%
(4) German	%
(5) Italian	%
(6) Portugese	%
(7) Spanish	%
(8) Vietnamese	%
(9) Other (PLEASE DESCRIBE)	
(a) _____	%
(b) _____	%
TOTAL	%

(NOTE: TOTAL SHOULD EQUAL 100%.)

15. Please provide the following information on the numbers and types of staff members employed at your prenatal clinic during the past month.

- In Column A, please enter the number of full-time (35 or more hours per week) staff of each type.
- In Column B, please enter the number of part-time (less than 35 hours per week) staff of each type.

STAFF POSITION	A FULL-TIME STAFF	B PART-TIME STAFF
(1) Nurse		
(2) Nutritionist or Dietitian		
(3) Nutrition aide		
(4) Home economist		
(5) Physician		
(6) Physician assistant		
(7) Family nurse practitioner		
(8) Field/social worker		
(9) Administrator		
(10) Clerk		
(11) Secretary		
(12) Other (PLEASE DESCRIBE) _____		

16. Do any of your staff members who have direct patient contact speak languages other than English?

(CIRCLE ONE.)

Yes 01
No. . . . . 02 } (GO TO QUESTION 17.)
Don't know. . . . . DK }

16. A. For each of the languages listed below, please enter the number of staff members who have direct patient contact who speak that language.

LANGUAGE	NUMBER OF STAFF
(1) Chinese	
(2) French	
(3) German	
(4) Italian	
(5) Portugese	
(6) Spanish	
(7) Vietnamese	
(8) Other (PLEASE DESCRIBE)	
(a) _____	
(b) _____	

17. How many staff at your clinic resigned, retired, or were terminated during calendar year 1982?

None. . . . . 00 (GO TO QUESTION 18.)

_____ number of staff terminations

A. Please enter the number of staff who stopped working at your clinic in 1982 for each of the reasons listed below.

REASON FOR TERMINATION	NUMBER OF STAFF
(1) Voluntary resignation	
(2) Retirement	
(3) Transfer out of clinic	
(4) Lay-off/reduction in force	
(5) Fired	
(6) Other (PLEASE DESCRIBE)	
_____	

18. How many new staff members were hired at your clinic in calendar year 1982?

None. . . . . 00 (GO TO QUESTION 19.)

_____ number of new staff

A. Please enter the number of staff who were hired in 1982 for each of the reasons listed below.

REASON FOR NEW HIRE	NUMBER OF STAFF
(1) New position(s) established	
(2) Increase in budget	
(3) Replace staff loss(es)	
(4) Fill vacant position(s) <u>not</u> related to staff loss	
(5) Other (PLEASE DESCRIBE) _____ _____	

19. Please record your name, title, and phone number.

NAME _____

TITLE _____

PHONE (_____) _____
Area Code

20. Please record the name, title, and phone number of the member of the clinic staff to whom further discussion or correspondence about this study should be directed.

NAME _____

TITLE _____

PHONE (_____) _____
Area Code

PLEASE ATTACH A BLANK COPY OF ALL FORMS (FOR EXAMPLE--REGISTRATION FORM, REFERRAL FORMS, PROGRESS NOTES, ETC.) THAT ARE COMPLETED AT THE TIME A NEW PATIENT APPLIES FOR SERVICES AT THIS CLINIC. THANK YOU.

(CHECK ONE.)

FORMS ATTACHED ☐

FORMS NOT AVAILABLE ☐

PLEASE HOLD THIS QUESTIONNAIRE FOR PICK-UP BY A STAFF MEMBER FROM RESEARCH TRIANGLE INSTITUTE OR NEW YORK STATE RESEARCH FOUNDATION, WHO WILL CONTACT YOU WITHIN THE NEXT TWO TO THREE WEEKS.

IF THERE IS A STAFF MEMBER PRIMARILY RESPONSIBLE FOR PROVIDING NUTRITION EDUCATION AT THIS PRENATAL CLINIC, PLEASE HAVE THAT PERSON COMPLETE THE NUTRITION EDUCATION QUESTIONNAIRE AND RETURN IT TO YOU.

IF THERE IS NO SPECIFIC STAFF MEMBER RESPONSIBLE FOR NUTRITION EDUCATION, WE WOULD APPRECIATE YOUR COMPLETING THE NUTRITION EDUCATION QUESTIONNAIRE.

IF NUTRITION EDUCATION IS NOT PROVIDED AT THIS PRENATAL CLINIC, PLEASE CHECK THIS BOX ☐ AND DISREGARD THE NUTRITION EDUCATION QUESTIONNAIRE.

THANK YOU!

OMB No. 0584-0306
Expires 12/31/83

WIC SITE ADMINISTRATOR'S QUESTIONNAIRE

A Study of
Health and Nutrition of Mothers and Their Children

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1. Please describe the geographic area that your WIC site serves. If complete counties are served, enter the county names in Column A. If partial counties or specified localities are served, enter the names of the cities, towns, or other jurisdictions in Column B.

A. COMPLETE COUNTIES	B. SPECIFIED LOCALITIES

A. Are there other WIC sites that serve any part of the service area described above?

(CIRCLE ONE.)

Yes. 01
No . . . . . 02 (GO TO QUESTION 2.)

B. Are the other WIC sites that serve any part of the service area described above included in the same WIC Program as your WIC site?

(CIRCLE ONE.)

All in same WIC Program 01
Some in same WIC Program. 02
None in same WIC Program. 03

2. What type of agency or organization sponsors this WIC site?

(CIRCLE ONE.)

Neighborhood/community health agency. 01
Community action agency 02
Municipal health agency 03
County health agency. 04
State or district health agency 05
Indian health agency. 06
Public hospital 07
Private voluntary hospital. 08
Private proprietary hospital. 09
Other (PLEASE DESCRIBE) 10

_____

_____

3. In the table below, please make the following entries for each type of client listed:

- In Column A, circle the code for "YES" or "NO" to indicate if each type of client is served by your WIC site.

- In Column B, enter the number of each type of client served who visits your WIC site in an average month.

- In Column C, enter the number of <u>new</u> clients, by type, who are certified at your WIC site in an average month.

	TYPE OF CLIENT	A SERVED?	B NUMBER PER MONTH	C <u>NEW</u> CLIENTS PER MONTH
(1)	Women clients	Yes. . . 01 No . . . 02		
	(a) Pregnant women	Yes. . . 01 No . . . 02		
	(b) Postpartum or lactating women	Yes. . . 01 No . . . 02		
(2)	Infants under 1 year	Yes. . . 01 No . . . 02		
(3)	Children 1 to 5 years	Yes. . . 01 No . . . 02		

4. Of all pregnant women who apply for WIC services at your site, approximately what percentage of the total applicants are deemed eligible to receive WIC services?

_____% eligible

A. Of those pregnant women who are deemed eligible to receive WIC services at your site, approximately what percentage are certified on the same day they apply for WIC benefits?

_____% certified immediately

IF 100% OF PREGNANT APPLICANTS RECEIVE SERVICES IMMEDIATELY, GO TO QUESTION 5 ON PAGE 4.

B. For pregnant women who, for one reason or another, have to wait to be deemed eligible for certification, what is the average waiting time, in weeks, from the date of application to the time of WIC certification?

_____ weeks' waiting time

C. For pregnant women who have to wait for certification, what criteria are used to select those who will be given priority for earliest service?

(CIRCLE ALL THAT APPLY.)

Order of certification (first come/ first served)	01
Anemia (low hemoglobin)	02
Poor diet	03
Low weight	04
Late gestation	05
Previous obstetrical problems	06
Income level	07
Other (PLEASE DESCRIBE)	08

_____

_____

5. In the table below, please provide the following information on the eligibility criteria for pregnant women who are served at your WIC site.

   - In Column A, circle the code for "YES" for each eligibility criterion that applies to pregnant women who are served. Circle the code for "NO" for each criterion that is not applicable at your WIC site.
   - In Column B, provide a definition of each applicable criterion.
   - In Column C, rank the applicable eligibility criteria in order of priority in providing service to pregnant women. The highest priority criterion should be ranked "1," the next highest "2," etc., until all applicable criteria have been ranked.

   If you have written definitions or explanations of eligibility criteria, please attach a copy to this questionnaire.

   If there are no specific eligibility criteria in effect for providing services to pregnant women, please check this box ☐ and go to Question 6.

ELIGIBILITY CRITERIA	A APPLICABLE?	B DEFINITION	C PRIORITY ORDER
(1) Inadequate diet	Yes . . . . 01 No 02		
(2) Anthropometric measurements (such as weight, weight gain, or height)	Yes . . . . 01 No 02		
(3) Hemoglobin or hematocrit (For example, hemoglobin ≤ 11 gms. or hematocrit ≤ 34%.)	Yes . . . . 01 No 02		
(4) Obstetrical risk factors	Yes . . . . 01 No 02		
(5) Income	Yes . . . . 01 No 02		
(6) Age (such as adolescents)	Yes . . . . 01 No 02		
(7) Other (PLEASE DESCRIBE)			
(a) _____	Yes . . . . 01 No 02		
(b) _____	Yes . . . . 01 No 02		

6. In the table below, please provide the following information on your WIC site's operating schedule for pregnant clients.

   - In Column A, circle the code for "YES" or "NO" to indicate if the site is open on each day of the week.
   - In Column B, enter all times each day that the site is open for services to pregnant clients. Always indicate "a.m." or "p.m." for times. (For example, 8:30 a.m. to 12:00 noon, 1:00 p.m. to 5:30 p.m., 7:00 p.m. to 9:00 p.m.)
   - In Column C, please enter the particular times during which initial visits with new pregnant clients are scheduled each day that the WIC site is open. If new pregnant clients are scheduled at any time during each day's operating hours, please check the "SAME" box.
   - In Column D, enter the particular times during which follow-up visits with pregnant clients are scheduled. If follow-up visits are scheduled at any time during each day's operating hours, please check the "SAME" box.
   - In Column E, circle the code that best describes the typical caseload of pregnant clients on each day that the site is open.

	A	B	C	D	E
DAY OF WEEK	SITE OPEN?	DAILY OPERATING HOURS	HOURS FOR NEW PREGNANT CLIENT VISITS	HOURS FOR FOLLOW-UP CLIENT VISITS	TYPICAL CASELOAD OF PREGNANT CLIENTS
(1) Monday	Yes. . 01 No . . 02		☐ Same	☐ Same	Light . . 01 Moderate. 02 Heavy . . 03
(2) Tuesday	Yes. . 01 No . . 02		☐ Same	☐ Same	Light . . 01 Moderate. 02 Heavy . . 03
(3) Wednesday	Yes. . 01 No . . 02		☐ Same	☐ Same	Light . . 01 Moderate. 02 Heavy . . 03
(4) Thursday	Yes. . 01 No . . 02		☐ Same	☐ Same	Light . . 01 Moderate. 02 Heavy . . 03
(5) Friday	Yes. . 01 No . . 02		☐ Same	☐ Same	Light . . 01 Moderate. 02 Heavy . . 03
(6) Saturday	Yes. . 01 No . . 02		☐ Same	☐ Same	Light . . 01 Moderate. 02 Heavy . . 03
(7) Sunday	Yes. . 01 No . . 02		☐ Same	☐ Same	Light . . 01 Moderate. 02 Heavy . . 03

6. A. Does the schedule outlined in Columns A and B above vary at any time during the year?

(CIRCLE ONE.)

Yes. 01
No . . . . . 02 (GO TO QUESTION 7.)

B. Please describe all variations in schedule.

_____

_____

_____

7. What type of food supplement system is offered to pregnant women by your WIC site?

(CIRCLE ALL THAT APPLY.)

Food instruments (such as vouchers or checks). 01
Delivery of food to client's home 02
Distribution of food at site. . . . . 03 (GO TO QUESTION 8.)
Other (PLEASE DESCRIBE) 04

_____

_____

A. Are food vouchers mailed to pregnant clients or must the clients always come to the WIC site to pick them up?

(CIRCLE ONE.)

Mailed to client . . . . . 01 (GO TO QUESTION 8.)
Client must pick up. 02

B. Does your WIC site require that food vouchers for a pregnant woman be picked up only by the client, or can someone else pick up the vouchers for her?

(CIRCLE ONE.)

Client only. 01
Someone else 02

C. At what interval are food vouchers dispensed to pregnant women?

(CIRCLE ONE.)

Weekly 01
Every 2 weeks. 02
Monthly. 03
Every 2 months 04
Other (PLEASE DESCRIBE). 05

_____

_____

7. D. Are there specific days or periods when food vouchers are dispensed, or can they be picked up at any time within the interval identified above?

(CIRCLE ONE.)

Specified days or periods 01
Any time . . . . . 02 (GO TO QUESTION 8.)

E. What are those days or periods?

_____

_____

8. At what interval do pregnant clients usually return to your WIC site for services after their initial visits?

(CIRCLE ONE.)

No set interval 01
Monthly 02
Every 6 weeks 03
Every 2 months. 04
Other interval (PLEASE DESCRIBE). 05

_____

_____

9. Does your WIC site...

(CIRCLE ONE NUMBER ON EACH LINE.)

	YES	NO
A. Provide or arrange transportation for clients to and from the WIC site?	01	02
B. Provide or arrange on-site child care during mothers' visits to the site?	01	02
C. Provide all services on a walk-in basis? . . .	01	02
D. Provide on-site prenatal care services? . . .	01	02

10. Does your WIC site have regular arrangements with any facilities to provide prenatal care services?

(CIRCLE ONE.)

Yes 01
No. . . . . 02 (GO TO QUESTION 11.)

10. A. What are the complete names and locations of these facilities?

(1) NAME _____

CITY AND STATE _____

(2) NAME _____

CITY AND STATE _____

(3) NAME _____

CITY AND STATE _____

(4) NAME _____

CITY AND STATE _____

(5) NAME _____

CITY AND STATE _____

(6) NAME _____

CITY AND STATE _____

(7) NAME _____

CITY AND STATE _____

(8) NAME _____

CITY AND STATE _____

11. As part of this project, certain laboratory studies of anemic and normal pregnant women will be conducted. What procedure is <u>usually</u> used at your WIC site for obtaining the first blood samples from pregnant women?

(CIRCLE ONE.)

Capillary sample (fingerstick) 01
Venipuncture . . . . . 02 (GO TO QUESTION 12.)
Neither. . . . . 03 (GO TO QUESTION 13.)

A. Are there facilities in your WIC site for obtaining blood samples by venipuncture?

(CIRCLE ONE.)

Yes 01
No. . . . . 02 (GO TO QUESTION 12.)

B. If a hemoglobin or hematocrit value is low, is the capillary sample <u>routinely</u> followed by a venipuncture sample?

(CIRCLE ONE.)

Yes 01
No. 02

12. For new patients who are making their first visit to your WIC site, when are the results of hemoglobin and hematocrit values from their first blood samples usually available?

(CIRCLE ONE.)

During visit. 01
Same day as visit 02
One or more days after visit
(PLEASE DESCRIBE) 03

_____

_____

13. Is there a beam balance scale for weighing adults in your WIC site?

(CIRCLE ONE.)

Yes 01
No. 02

14. For each of the languages listed below, please enter the percentage of your total clients who speak the language as their principal language. (If exact percentages are not known, please provide your best estimate.)

LANGUAGE	PERCENT OF CLIENTS
(1) Chinese	%
(2) English	%
(3) French	%
(4) German	%
(5) Italian	%
(6) Portugese	%
(7) Spanish	%
(8) Vietnamese	%
(9) Other (PLEASE DESCRIBE)	
(a) _____	%
(b) _____	%
TOTAL	%

(NOTE: TOTAL SHOULD EQUAL 100%.)

15. How many staff members at your WIC site are paid in full with WIC Program funds? (Please include full-time and part-time staff members in this number.)

_____ staff paid in full with WIC funds

A. How many staff members at your WIC site are paid in part with WIC Program funds? (Please include full-time and part-time staff members in this number.)

_____ staff paid in part with WIC funds

16. Please provide the following information on the numbers and types of staff members at your WIC site who are paid in full or in part with WIC Program funds.

- In Column A, please enter the number of full-time (35 or more hours per week) staff of each type.

- In Column B, please enter the number of part-time (less than 35 hours per week) staff of each type.

STAFF POSITION	A FULL-TIME STAFF	B PART-TIME STAFF
(1) Nurse		
(2) Nutritionist or Dietitian		
(3) Nutrition aide		
(4) Home economist		
(5) Physician		
(6) Physician assistant		
(7) Family nurse practitioner		
(8) Field/social worker		
(9) Administrator		
(10) Clerk		
(11) Secretary		
(12) Other (PLEASE DESCRIBE) _____		

17. Do any of the staff members accounted for in the table on the preceding page who have direct client contact speak languages other than English?

(CIRCLE ONE.)

Yes 01
No. . . . . 02 } (GO TO QUESTION 18.)
Don't know. . . . . DK }

A. For each of the languages listed below, please enter the number of staff members who have direct client contact who speak that language.

LANGUAGE	NUMBER OF STAFF
(1) Chinese	
(2) French	
(3) German	
(4) Italian	
(5) Portugese	
(6) Spanish	
(7) Vietnamese	
(8) Other (PLEASE DESCRIBE)	
(a) _____	
(b) _____	

18. How many staff at your WIC site (paid in full or in part with WIC funds) resigned, retired, or were terminated during calendar year 1982?

None. . . . . 00 (GO TO QUESTION 19.)

_____ number of staff terminations

A. Please enter the number of staff who stopped working at your WIC site in 1982 for each of the reasons listed below.

REASON FOR TERMINATION	NUMBER OF STAFF
(1) Voluntary resignation	
(2) Retirement	
(3) Transfer out of WIC site	
(4) Lay-off/reduction in force	
(5) Fired	
(6) Other (PLEASE DESCRIBE) _____	

19. How many new staff members (paid in full or in part with WIC funds) were hired at your WIC site in calendar year 1982?

None. . . . . 00 (GO TO QUESTION 20.)

_____ number of new staff

A. Please enter the number of staff who were hired in 1982 for each of the reasons listed below.

REASON FOR NEW HIRE	NUMBER OF STAFF
(1) New position(s) established	
(2) Increase in budget	
(3) Replace staff loss(es)	
(4) Fill vacant position(s) not related to staff loss	
(5) Other (PLEASE DESCRIBE) _____ _____	

20. Please record your name, title, and phone number.

NAME _____

TITLE

PHONE ( ) _____
Area Code

21. Please record the name, title, and phone number of the member of your staff to whom further discussion or correspondence about this study should be directed.

NAME _____

TITLE _____

PHONE ( ) _____
Area Code

PLEASE ATTACH A BLANK COPY OF ALL FORMS (FOR EXAMPLE--APPLICATION, INCOME OR FINANCIAL ELIGIBILITY STATEMENT, REFERRAL FORMS, PROGRESS NOTES, ETC.) THAT ARE COMPLETED AT THE TIME A PREGNANT WOMAN APPLIES FOR SERVICES AT THIS WIC SITE.

(CHECK ONE.)

FORMS ATTACHED ☐

FORMS NOT AVAILABLE ☐

PLEASE HOLD THIS QUESTIONNAIRE FOR PICK-UP BY A STAFF MEMBER FROM RESEARCH TRIANGLE INSTITUTE OR NEW YORK STATE RESEARCH FOUNDATION, WHO WILL CONTACT YOU WITHIN THE NEXT TWO TO THREE WEEKS.

IF THERE IS A STAFF MEMBER PRIMARILY RESPONSIBLE FOR PROVIDING NUTRITION EDUCATION AT THIS WIC SITE, PLEASE HAVE THAT PERSON COMPLETE THE NUTRITION EDUCATION QUESTIONNAIRE AND RETURN IT TO YOU.

IF THERE IS NO SPECIFIC STAFF MEMBER RESPONSIBLE FOR NUTRITION EDUCATION, WE WOULD APPRECIATE YOUR COMPLETIING THE NUTRITION EDUCATION QUESTIONNAIRE.

IF NUTRITION EDUCATION IS NOT PROVIDED AT THIS WIC SITE, PLEASE CHECK THIS BOX ☐ AND DISREGARD THE NUTRITION EDUCATION QUESTIONNAIRE.

THANK YOU!

REVISED 04/06/83

WIC SITE SCREENING FORM
A Study of Health and Nutrition
of Mothers and Their Children

OMB No. 0584-0306
Expires 12/31/83

INSTRUCTIONS: PLEASE COMPLETE THIS FORM ON THE DAY OF CERTIFICATION FOR EACH WOMAN WHO IS CERTIFIED AS ELIGIBLE TO RECEIVE WIC SERVICES.

WOMAN'S NAME (FIRST, MIDDLE, LAST)		DATE OF SCREENING ☐☐ Month ☐☐ Day ☐☐ Year	
STREET ADDRESS		TELEPHONE NUMBER ( )	
CITY	STATE	ZIP	RECORD/WIC NUMBER

PSU #	CLINIC #	OPERATIVE NAME	ID #

ELIGIBILITY SUMMARY
(CIRCLE ONE.)
01 Eligible
02 Ineligible--prior WIC certification
04 Ineligible--moving more than 1 hour/ 45 miles from WIC site

SCREENING ID LABEL
(TO BE ASSIGNED BY FIELD OPERATIVE FOR ELIGIBLE WOMEN ONLY.)

1. Since you became pregnant this time, have you been certified eligible to receive any WIC services or benefits before today?

   Yes . . . . . 01 (CONCLUDE CONTACT; INELIGIBLE, CIRCLE CODE 02 ABOVE.)
   No. 02

   A. Since you became pregnant this time, have you sought or applied for WIC services or benefits before today?

      Yes. . . 01
      No . . . 02 (Q. 2.)

   B. On what date did you first seek or apply for WIC services for this pregnancy?

      ☐☐ Month ☐☐ Day ☐☐ Year

      IF EXACT DATE UNKNOWN, PROBE: How many days or weeks ago was that?

      ☐☐ Days OR ☐☐ Weeks

2. How many weeks or months pregnant are you?

☐☐ Weeks OR ☐☐ Months

Don't know → (CHECK WITH MEDICAL STAFF AND RECORD DURATION OF GESTATION.)

3. Do you have any plans to move away from this area before your baby is born?

Yes 01
No. 02
Don't know. . DK
} (INSTRUCTION BOX.)

A. Where do you plan to move?

CITY _____

COUNTY _____ STATE _____

IF RESPONDENT PLANS TO MOVE TO DIFFERENT ADDRESS IN CITY AND/OR COUNTY WHERE WIC SITE IS LOCATED, GO TO INSTRUCTION BOX.

B. IF OUT OF COUNTY WHERE WIC SITE IS LOCATED, ASK:

How long does it take to drive from here to where you plan to move?

☐☐ Minutes OR ☐☐ Hours

(IF MORE THAN 1 HOUR, CONCLUDE CONTACT; INELIGIBLE, CIRCLE CODE 04 ABOVE.)
(IF 1 HOUR OR LESS, GO TO INSTRUCTION BOX.)

Don't know → (CHECK MAP OR CONSULT OTHER STAFF AND RECORD ESTIMATE OF DRIVING TIME.)

C. IF OUT OF STATE, ASK: About how many miles is that from here?

☐☐☐☐ Miles (IF MORE THAN 45 MILES, CONCLUDE CONTACT; INELIGIBLE, CIRCLE CODE 04 ABOVE.)

Don't know . . DK (D.)

D. About how long does it take to drive from here to where you plan to move in (STATE)?

☐☐ Minutes OR ☐☐ Hours

(IF MORE THAN 1 HOUR, CONCLUDE CONTACT; INELIGIBLE, CIRCLE CODE 04 ABOVE.)
(IF 1 HOUR OR LESS, GO TO INSTRUCTION BOX.)

Don't know → (CHECK MAP OR CONSULT OTHER STAFF AND RECORD ESTIMATE OF DRIVING TIME.)

INSTRUCTION BOX

AN ELIGIBLE WOMAN HAS BEEN IDENTIFIED.

- CIRCLE CODE 01 IN ELIGIBILITY SUMMARY.
- ASK WOMAN TO SIGN CONSENT FORM.
- COMPLETE INITIAL INTERVIEW PACKAGE.
- IF WOMAN IS 32 WEEKS OR MORE OR 8 MONTHS OR MORE PREGNANT, COMPLETE SPECIAL FOLLOW-UP SUPPLEMENT IN ADDITION TO INITIAL INTERVIEW PACKAGE.

OMB No. 0584-0306
Expires 12/31/83

WOMEN'S INITIAL INTERVIEW PACKAGE

A Study of
Health and Nutrition of Mothers and Their Children

Sponsored by

Food and Nutrition Service
U.S. Department of Agriculture

Conducted by

New York State Research Foundation
and
Research Triangle Institute

INITIAL INTERVIEW ID LABEL

INVENTORY Included with this package are:

		Number	
☐	Screening Form		
☐	Consent Form (White)	_____	Child's Consent Form(s) (White)
☐	Women's Initial Interview Package	_____	Child's Interview Package(s)
☐	Authorization Form		
☐	Hospital Records Abstract Form		
☐	Follow-up Interview Data Sheet		
☐	Continuation Section for Pregnancy and Live Birth History		

RESPONDENT NAME (FIRST, MIDDLE, LAST)			
STREET ADDRESS			APT. NO.
CITY/TOWN/VILLAGE	COUNTY	STATE	ZIP
RESPONDENT PHONE ( )	OTHER PHONE ( )	IF OTHER PHONE, NAME:	
SOCIAL SECURITY NUMBER ☐☐☐ - ☐☐ - ☐☐☐☐	MEDICAID COVERAGE? Yes . . . . . 01 No 02		
MEDICAL/WIC RECORD NUMBER	RACE OF RESPONDENT (BY OBSERVATION) White . . . . . 01 Black . . . . . 02 Oriental. . . . . 03 American Indian . . . . . 04 Other (SPECIFY) 05		
DATE OF THIS VISIT ☐☐ ☐☐ ☐☐ Month Day Year			
PSU #	CLINIC #	OPERATIVE NAME	ID #

INSTRUCTIONS

- HAVE CONSENT FORM SIGNED.
- COMPLETE DIETARY INTERVIEW ON DAY OF FIRST WIC SITE/CLINIC VISIT IF SAMPLING MESSAGE ON ACF READS "IN DIETARY INTERVIEW SAMPLE."
- CONTINUE WITH INITIAL QUESTIONNAIRE.
- IF RESPONDENT HAS 1 OR MORE CHILDREN 0 THROUGH 4 YEARS OLD, SELECT SAMPLE CHILD AND ARRANGE FOR HOME VISIT TO COMPLETE DATA COLLECTION FOR SAMPLE CHILD AND ANY OTHER ELIGIBLE 4- OR 5- YEAR-OLD CHILD(REN).
- HAVE AUTHORIZATION FORM SIGNED.
- TAKE MEASUREMENTS AND RECORD ON MEASUREMENT FORM.
- COMPLETE SECTION A OF FOLLOW-UP INTERVIEW DATA SHEET.
- COMPLETE SECTION A OF HOSPITAL RECORDS ABSTRACT FORM IF RESPONDENT SIGNED AUTHORIZATION FORM.

Start Time _____ am
pm

WOMEN'S DIETARY INTERVIEW

(24-HOUR RECALL)

DATE COMPLETED

Month	Day	Year

DAY OF WEEK

Monday 01
Tuesday. 02
Wednesday. . . . 03
Thursday 04
Friday 05
Saturday 06
Sunday 07

MEASUREMENT CONVERSIONS

3 teaspoons = 1 tablespoon
2 tablespoons = 1 fluid ounce
4 tablespoons = ¼ cup
5 1/3 tablespoons = 1/3 cup
16 tablespoons = 1 cup = 8 ounces = ½ pint
2 cups = 1 pint
2 pints = 1 quart

NOTES: _____

	WORKSPACE	TOTAL AMOUNT	CODE
Whole Milk		oz	001
Skim Milk		oz	002
1% Milk		oz	003
2% Milk		oz	004
Buttermilk		oz	005
Chocolate Milk		oz	006
Hot Chocolate/Cocoa		oz	007
Evaporated Milk		oz	008
Nonfat Dry Milk, Prepared		oz	009
Ice Cream Flavors, Not Chocolate		C	010
Ice Cream, Chocolate		C	011
Sugar Cone		ea	012
Pudding, Chocolate Mix		C	013
Pudding, Vanilla Mix		C	014
Yogurt, Plain, Low Fat		C	015
Yogurt, Fruit, Low Fat		C	016
American Processed Cheese			017
American Cheese Food			018
American Cheese Food Spread		T	019
Cheddar/Brick Cheese			020
Colby Cheese			021
Cottage Cheese		C	022
Monterey Jack Cheese			023
Mozzarella Cheese			024
Muenster Cheese			025
Parmesan Cheese, Grated		t	026
Provolone Cheese			027
Swiss Cheese			028
Other:			

NOTES: _____

MEAT
POULTRY
EGGS

	WORKSPACE	TOTAL AMOUNT			CODE
Beef/Veal/Lamb:					
Beef, Ground/Hamburger					029
Corned Beef/Pastrami					030
Lamb					031
Meatloaf/Meatballs					032
Pot Roast					033
Ribs, Braised					034
Roast Beef					035
Salisbury Steak					036
Steak, Broiled, Fat Trimmed					037
Steak, Broiled, Fat Not Trimmed					038
Steak, Fried					039
Veal, Chop or Roast					040
Veal Cutlet, Fried					041
Pork:					
Bacon				sl	042
Chops/Steak					043
Ham, Cured					044
Ham Hocks				ea	045
Ham Salad				T	046
Pork, Neckbones				ea	047
Pork, Pigs Feet, Pickled				ea	048
Pork Roast					049
Spareribs, Braised					050
Sausages and Luncheon Meats:					
Beef, Pressed					051
Bologna, All Kinds					052
Deviled Ham/Spam				T	053
Frankfurter, All Kinds				ea	054
Ham, Boiled, Lunchmeat					055
Liverwurst					056
Luncheon Loaf w/Olive, Pickle, Pimento					057
Polish/Italian Sausage					058
Pork Sausage					059
Salami/Pepperoni/Summer Sausage					060
Poultry and Eggs:					
Chicken Breast, Fried				ea	061
Chicken Drumstick, Fried				ea	062
Chicken Thigh, Fried				ea	063
Chicken Wing, Fried				ea	064
Chicken/Turkey, Roast w/ Skin					065
Chicken/Turkey, Roast w/o Skin					066
Eggs, Scrambled				ea	067
Eggs, Hard or Soft Cooked, Poached or Fried				ea	068
Egg Salad				T	069
Other:					

	WORKSPACE	TOTAL AMOUNT	CODE
Fish and Seafood:			
Cod/Flounder, Baked			070
Cod, Salt			071
Fish/Catfish, Fried			072
Fish Sticks			073
Haddock, Broiled			074
Shrimp, Canned		C	075
Shrimp, Fried		C	076
Tuna, Canned in Oil, Drained Solids		C	077
Tuna, Canned in Water		C	078
Tuna Salad		T	079
Meat Alternates:			
Beans, Black, Cooked		C	080
Beans, Fried/Refried, Cooked		C	081
Beans, Garbanzo/Chick Peas, Cooked		C	082
Beans, Lima, Mature, Cooked		C	083
Beans, Pinto/Calico, Cooked		C	084
Beans, Red/Kidney, Cooked		C	085
Beans, White/Navy, Cooked		C	086
Lentils, Cooked		C	087
Peanut Butter		T	088
Peanuts		T	089
Peas, Blackeyed/Cowpeas, Cooked		C	090
Peas, Split, Cooked		C	091
Soups (Ready-To-Serve):			
Bean		C	092
Broth/Consommé, Beef, Canned		C	093
Broth/Consommé, Chicken, Canned		C	094
Chicken Noodle		C	095
Chicken Rice		C	096
Codfish Soup w/Noodles, Puerto Rican Style		C	097
Cream of Chicken		C	098
Cream of Mushroom		C	099
Cream of Potato		C	100
Cream of Tomato		C	101
Fish Chowder		C	102
Tomato		C	103
Vegetable Beef		C	104
Vegetable Noodle		C	105
Vegetarian Vegetable		C	106
Other:			

CASSEROLES
HONEY, SUGAR, SYRUP
CONDIMENTS

	WORKSPACE	TOTAL AMOUNT	CODE
Casseroles and Combinations (Ready-To-Serve):			
Beef and Vegetable Stew		C	107
Beef, Ground w/Vegetables Casserole		C	108
Beef, Pot Pie, 4"		ea	109
Burritos (Tortilla, Meat, Refried Beans)		ea	110
Chicken and Dumplings		C	111
Chicken/Turkey Pot Pie, 4"		ea	112
Chili Con Carne w/Beans		C	113
Chili Con Carne w/o Beans		C	114
Goulash, Beef w/Noodles		C	115
Lasagna			116
Macaroni and Cheese		C	117
Macaroni w/Chicken		C	118
Macaroni w/Tuna		C	119
Pizza, Cheese			120
Pizza, Meat & Cheese			121
Pork and Beans		C	122
Ravioli, w/Meat		C	123
Spaghetti, Meat & Tomato Sauce		C	124
Spaghetti, Cheese & Tomato Sauce			125
Honey, Sugar, Syrup:			
Honey		t	126
Jams/Jellies		t	127
Sugar		t	128
Molasses		t	129
Chocolate Syrup, Thin Type		t	130
Chocolate Topping, Thick Fudge Type		t	131
Chocolate Powder		t	132
Pancake Syrup		t	133
Condiments:			
B-B-Q Sauce		t	134
Catsup		t	135
Mustard		t	136
Pickle, Dill, 3 3/4" Long x 1 1/4" Thick		ea	137
Pickle Relish		t	138
Pickle, Sweet, 2 1/2" Long x 3/4 " Thick		ea	139
Tomato Chili Sauce		t	140
Other:			

	WORKSPACE	TOTAL AMOUNT	CODE
Apple, Baked w/Sugar		ea	141
Apple Juice		oz	142
Apple, Raw		ea	143
Apple Sauce		C	144
Apricots, Canned, Heavy Syrup		C	145
Avocado, Raw		ea	146
Banana, Raw		ea	147
Cantelope, Raw		C	148
Cranberry Juice		oz	149
Cranberry Sauce		T	150
Fruit Cocktail, Canned, Heavy Syrup		C	151
Grapefruit Juice		oz	152
Grapefruit, Raw		ea	153
Grape Juice		oz	154
Grapes, Raw		C	155
Lemon Juice		t	156
Lemon, Raw		sl	157
Orange Juice		oz	158
Orange, Raw		ea	159
Orange-Grapefruit Juice		oz	160
Peaches, Canned, Heavy Syrup		C	161
Peach, Raw		ea	162
Pineapple, Canned, Heavy Syrup		C	163
Pineapple Juice		oz	164
Plum, Raw		ea	165
Prune, Dried		ea	166
Raisins		T	167
Strawberries, Raw		C	168
Tangelos/Tangerines, Raw		ea	169
Watermelon, Raw		C	170
Other:			

NOTES: _____

VEGETABLES

	WORKSPACE	TOTAL AMOUNT	CODE
Asparagus, Cooked		C	171
Beans, Baby Limas, Cooked		C	172
Beans, Green or Yellow Snap		C	173
Bean Sprouts, Raw		C	174
Beets, Cooked		C	175
Broccoli, Cooked		C	176
Brussel Sprouts, Cooked		C	177
Cabbage, Cooked		C	178
Carrots, Cooked		C	179
Carrots, Raw		ea	180
Cauliflower, Cooked		C	181
Celery Stalk, Raw		ea	182
Coleslaw, All Types		C	183
Collard Greens, Cooked		C	184
Corn on Cob, Cooked, Ear		ea	185
Corn, Cream Style, Cooked		C	186
Corn, White Kernel, Cooked		C	187
Cucumbers, Raw		ea	188
Lettuce, Head & Leaf		C	189
Mixed Vegetables, Cooked		C	190
Mushrooms, Cooked		C	191
Mustard/Turnip Greens, Cooked		C	192
Okra, Cooked		C	193
Onions, Green/Scallions, Raw		ea	194
Onions, Mature, Raw		C	195
Peas, Green, Cooked		C	196
Peas and Carrots, Cooked		C	197
Peppers, Sweet Green, Raw		C	198
Potatoes, Au Gratin		C	199
Potatoes, Baked in Skin		ea	200
Potatoes, Boiled		ea	201
Potatoes, Creamed/Scalloped		C	202
Potatoes, Hash Browns/Home Fries		C	203
Potatoes, French Fried		C	204
Potatoes, Mashed		C	205
Potato Salad		C	206
Radishes, Raw		ea	207
Salad, Tossed (Lettuce & Tomato)		C	208
Sauerkraut		C	209
Spinach, Cooked		C	210
Squash, Summer/Zucchini, Cooked		C	211
Squash, Winter		C	212
Sweet Potatoes, Baked		ea	213
Sweet Potatoes, Candied		C	214
Tomatoes, Canned		C	215
Tomatoes, Raw		ea	216
Tomato Sauce		C	217
Turnips, Cooked		C	218
Other:			

	WORKSPACE	TOTAL AMOUNT	CODE
Bread Stuffing/Dressing		C	219
Breadcrumbs, Dry (Commercial)		T	220
Breads:			
Bagels		ea	221
Biscuits		ea	222
Cornbread			223
English Muffin		ea	224
French Bread (2½" wide)		sl	225
Hamburger/Frankfurter Bun		ea	226
Muffin, Blueberry		ea	227
Rolls:			
Cinnamon Bun		ea	228
Dinner/Soft, Brown'Serve		ea	229
Hard/Kaiser		ea	230
Hoagie/Submarine (11½" x 3" x 2½")		ea	231
Rye Bread		sl	232
White Bread		sl	233
Wheat Bread		sl	234
Corngrits/Hominy Grits		C	235
Cornbread Stuffing/Dressing		C	236
Crackers:			
Butter		ea	237
Graham		ea	238
Soda/Saltines, 2" Square		ea	239
Wheat		ea	240
Croutons, Plain, Toasted		T	241
French Toast, Plain, Homemade		sl	242
Macaroni/Noodles, Cooked		C	243
Pancakes, Waffles			244
Rice, Brown, Cooked		C	245
Rice, Fried, Cooked		C	246
Rice, White, Cooked		C	247
Rice, Spanish, Cooked		C	248
Spaghetti, Plain, Cooked		C	249
Spoonbread		C	250
Tortilla, Corn		ea	251
Tortilla, Wheat		ea	252
Other:			

NOTES: _____

_____

_____

CEREALS
BEVERAGES

	WORKSPACE	TOTAL AMOUNT	CODE
Cereals:			
All Bran/Bran Buds		C	253
Body Buddies		C	254
Bran Flakes, 40% Kellogs		C	255
Cap'n Crunch		C	256
Cheerios		C	257
Corn Flakes, Not Country		C	258
Corn, Puffed (Kix)		C	259
Country Corn Flakes/Corn Total		C	260
Cream of Wheat, Regular		C	261
Cream of Wheat, Mix and Eat		C	262
Cream of Wheat, Mix and Eat, Flavored		C	263
Fruit Loops/Trix		C	264
Granola-type Cereals		C	265
Kaboom		C	266
King Vitamin		C	267
Malt-O-Meal, Chocolate & Plain		C	268
Maypo		C	269
Most		C	270
Oat Flakes, Fortified		C	271
Oatmeal		C	272
Product 19		C	273
Raisin Bran		C	274
Rice Krispies/Rice, Frosted/Sugar Corn Pops		C	275
Rice, Puffed		C	276
Sugar Frosted Flakes/Sugar Smacks		C	277
Total		C	278
Wheat, Shredded		C	279
Wheaties		C	280
Alcoholic Beverages:			
Beer		oz	281
Beer, Lite		oz	282
Dessert Wine/Sherry/Vermouth		oz	283
Wine, Table		oz	284
Whiskey/Spirits		oz	285
Nonalcoholic Beverages:			
Chocolate/Malted Milk Drink		oz	286
Coffee		oz	287
Hawaiian Punch (w/Vitamin C)		oz	288
Hi-C Fruit Drink (w/Vitamin C)		oz	289
Koolaid (w/Vitamin C)		oz	290
Lemonade		oz	291
Orange Drink/Pineapple Orange Drink		oz	292
Soda, Diet		oz	293
Soda, Regular		oz	294
Tea		oz	295
Tea, Premade w/Lemon & Sugar		oz	296
Other:			

	WORKSPACE	TOTAL AMOUNT	CODE
Cakes:			
Brownies			297
Chocolate/Devil's Food Cake w/Icing			298
Coffee Cake			299
Cup Cake w/Icing, Chocolate, 2 3/4" diameter		ea	300
Cup Cake w/Icing, Not Chocolate, 2 3/4" diameter		ea	301
Doughnuts, Plain (Cake), 3 1/2" x 1"		ea	302
Doughnuts, Glazed and Chocolate, 3 1/2" x 1"		ea	303
Pound Cake, Plain			304
Cookies:			
Animal Crackers		ea	305
Assorted Cookies			306
Butterscotch Chips			307
Chocolate Chip			308
Oatmeal/Raisin			309
Peanut			310
Sandwich Type			311
Sugar/Butter			312
Vanilla Wafers			313
Pies:			
Apple			314
Cherry			315
Chocolate			316
Lemon Meringue			317
Peach			318
Pumpkin/Squash			319
Candy:			
Caramels, Plain or Chocolate		ea	320
Chocolate, Milk, Plain			321
Fudge			322
Gum, Chewing		ea	323
Gumdrops		ea	324
Hard Candy		ea	325
Marshmallows		ea	326
Other Desserts:			
Jello, Plain		C	327
Jello, w/Fruit		C	328
Peach Cobbler		C	329
Popsicle		ea	330
Other:			

FATS AND OILS
SNACK CHIPS

	WORKSPACE	TOTAL AMOUNT	CODE
Fats and Oils:			
Butter		t	331
Cream Cheese		T	332
Cream, Half and Half		t	333
Cream, Heavy		t	334
Cream, Sour		t	335
Cream Substitute, Dry		t	336
Cream Substitute, Liquid		t	337
Cream, Whipped Topping, Non-Dairy Frozen		T	338
Gravy, Brown		T	339
Gravy, Milk		T	340
Lard		T	341
Mayonnaise		t	342
Margarine, Regular		t	343
Margarine, Whipped		t	344
Margarine, Diet		t	345
Oils, Salad & Cooking		T	346
Salad Dressings:			
Blue/Roquefort Cheese		T	347
French, Regular		T	348
French, Lo-Cal		T	349
Italian, Regular		T	350
Italian, Lo-Cal		T	351
Mayonnaise Type		T	352
Cream Type		T	353
Thousand Island		T	354
Shortening, Vegetable		t	355
White Sauce		t	356
Snack Chips:			
Corn Chips/Corn Curls		C	357
Popcorn		C	358
Potato Chips		C	359
Pretzels, Hard Stick		C	360
Other:			

NOTES: _____

1. Is what you ate yesterday the way you usually eat?

Yes . . . . . 01 (Q. 2.)
No. 02

A. Why was what you ate yesterday different?

Illness. 01
No money 02
Sunday or holiday. 03
Other (SPECIFY). 04

_____

_____

2. Are you on a special diet?

Yes 01
No. . . . . 02 (Q. 3.)

A. Why are you on this diet?

(CIRCLE ALL THAT APPLY.)

Lose weight. 01
Gain weight. 02
Diabetes 03
Kidney failure 04
Ulcers 05
Diverticulitis 06
Allergies. 07
Heart trouble. 08
High blood pressure. 09
Pregnancy. 10
Other (SPECIFY). 11

_____

B. What kind of diet is it?

(CIRCLE ALL THAT APPLY.)

Low calorie or weight reduction. . 01
Low fat. 02
Low protein. 03
High protein 04
Low salt 05
Low carbohydrate 06
Low sugar. 07
High calorie 08
Low cholesterol. 09
Vegetarian with animal by-products (eggs, dairy, etc.) . . 10
Vegetarian without animal by-products 11
Bland diet 12
Other (SPECIFY). 13

_____

3. Are you taking any vitamins or minerals?

Yes 01
No. . . . . 02 (Q. 4.)

A. What brand and type of vitamin or mineral supplements do you take? ENTER BRAND NAME AND DESCRIPTION IN TABLE. SHOW VITAMIN/MINERAL BOOKLET, IF NECESSARY, TO DETERMINE BRAND.

B. How often do you take (NAME/DESCRIPTION)? ENTER TIMES IN TABLE.

C. (ASK IF NECESSARY:) Is that per day or some other interval? ENTER INTERVAL IN TABLE.

D. Was this prescribed or recommended by a medical person? CODE "YES" OR "NO" IN TABLE

	A	B	C	D
	BRAND NAME AND DESCRIPTION	TIMES	INTERVAL	PRESCRIBED OR RECOMMENDED?
(1)				Yes . . . 01 No. . . . 02
(2)				Yes . . . 01 No. . . . 02
(3)				Yes . . . 01 No. . . . 02
(4)				Yes . . . 01 No. . . . 02

4. Were you advised to take any vitamin or mineral supplements that you do not take?

Yes 01
No. 02
Don't know/remember . . . . DK

End Time _____ am
pm

INSTRUCTION BOX

- IF RESPONDENT HAS TIME NOW, COMPLETE INITIAL QUESTIONNAIRE AND THEN DO MEASUREMENTS.
- IF RESPONDENT'S TIME IS LIMITED, DO MEASUREMENTS NOW AND SCHEDULE APPOINTMENT FOR INITIAL QUESTIONNAIRE COMPLETION.

WOMEN'S INITIAL QUESTIONNAIRE

Start Time _____ am pm

A. CURRENT PREGNANCY

Now I have some questions about this pregnancy.

CHECKPOINT A

☐ RESPONDENT ID NUMBER BEGINS WITH "1" → Q. A-1.

☐ RESPONDENT ID NUMBER BEGINS WITH "2" → Q. A-3.

A-1. When did you first seek medical care for this pregnancy?

☐☐ Month ☐☐ Day ☐☐ Year

Medical care not yet received. . . 00 (A-3.)

IF EXACT DATE UNKNOWN, PROBE: How many weeks pregnant were you when you first got medical care for this pregnancy?

☐☐ Weeks pregnant

Don't know . . . . . DK

A-2. How many visits have you made for medical care during this pregnancy (not counting today's visit)?

☐☐ Visits

Don't know . . . . . DK

A-3. How much did you weigh when you became pregnant (this time)?

☐☐☐ Pounds

A-4. On what date did your last menstrual period begin?

☐☐ Month ☐☐ Day ☐☐ Year

A-5. Where do you plan to deliver this baby?

FACILITY NAME _____

CITY _____

COUNTY _____ STATE _____

Don't know/undecided. . . . DK

A-6. Do you currently smoke one or more cigarettes a day?

Yes. 01
No 02 (A-7.)

A. About how many cigarettes do you currently smoke a day?

☐☐ Cigarettes per day

B. What brand of cigarettes do you usually smoke?

_____ Brand

C. Are these filtered or non-filtered?

Filtered. 01
Non-filtered. . . 02
Don't know. . . . DK

D. When you became pregnant (this time), about how many cigarettes did you smoke a day?

☐☐ Cigarettes per day

Did not smoke . . 00

A-7. In an average week, on how many days do you drink (BEVERAGE)? ENTER NUMBER OF DAYS IN TABLE. IF NONE, ENTER "0."

A. ASK FOR EACH BEVERAGE CONSUMED: On the days that you drink (BEVERAGE), how many (SPECIFIED MEASURE) do you usually drink? ENTER NUMBER IN TABLE.

BEVERAGE	DAYS PER WEEK	NUMBER	MEASURE
(1) Tea			6 oz. cups or glasses
(2) Coffee			6 oz. cups
(3) Table wine			4 oz. glasses
(4) Sherry, vermouth or dessert wine			2 oz. glasses
(5) Beer or alcoholic malta			12 oz. cans/bottles
(6) Mixed drinks, whiskey, or other liquors			1½ oz. shots

A-8. Not counting this pregnancy, how many times have you been pregnant, including live births, still births, miscarriages, and abortions? IF NONE, ENTER 00.

☐☐ Pregnancies

CHECKPOINT B

☐ Respondent has no previous pregnancies → SECTION C., PAGE 28.

☐ Respondent has one or more previous pregnancies → SECTION B.

B. PREGNANCY AND LIVE BIRTH HISTORY

Now I would like to ask you about all of your past pregnancies, including live births, stillbirths, miscarriages, and abortions.

ASK Qs. B-1 THROUGH B-15, AS APPLICABLE, FOR EACH PREGNANCY, BEGINNING WITH THE EARLIEST.

		PREGNANCY #1
B-1.	On what date did your [first/ second/etc.] pregnancy end?	☐☐ Month ☐☐ Day ☐☐ Year
B-2.	How many weeks pregnant were you when this pregnancy ended?	☐☐ Weeks OR ☐☐ Months
B-3.	Did this pregnancy end in a miscarriage, an induced abortion, or a tubal pregnancy?	Yes . . . . . 01 No. 02 (B-4.)
	A. Which was that--a miscarriage, induced abortion, or a tubal pregnancy?	Miscarriage . 01 Abortion. . . 02 Tubal pregnancy . 03 } LINE THROUGH Qs. B-4. THROUGH B-15. IN THIS COLUMN. GO TO NEXT PREGNANCY.
B-4.	Were you enrolled in the WIC program during this pregnancy?	Yes . . . . . 01 No. 02 (B-5.)
	A. How many weeks or months did you receive WIC services during this pregnancy?	☐☐ Weeks OR ☐☐ Months
B-5.	Was this a single birth or did you have twins or triplets?	Single . . 01 Twins. . . 02 Triplets . 03 } CONTINUE IN THIS COLUMN FOR FIRST-BORN BABY. COMPLETE MULTIPLE BIRTH RECORD FOR OTHER BABY(IES).
B-6.	Was [this baby/the baby born first] a live birth or a stillbirth?	Live birth . . 01 Stillbirth . . 02 → LINE THROUGH Qs. B-7. THROUGH B-15. IN THIS COLUMN. GO TO NEXT PREGNANCY.
B-7.	Was [this baby/the baby born first] a boy or a girl?	Boy . . . . . 01 Girl. 02

PREGNANCY #2	PREGNANCY #3	PREGNANCY #4
Month Day Year	Month Day Year	Month Day Year
Weeks OR Months	Weeks OR Months	Weeks OR Months
Yes . . . . . 01 No. 02 (B-4.)	Yes . . . . . 01 No. 02 (B-4.)	Yes . . . . . 01 No. 02 (B-4.)
Miscarriage . 01 Abortion. . . 02 Tubal pregnancy . 03 LINE THROUGH Qs. B-4. THROUGH B-15. IN THIS COLUMN. GO TO NEXT PREGNANCY.	Miscarriage . 01 Abortion. . . 02 Tubal pregnancy . 03 LINE THROUGH Qs. B-4. THROUGH B-15. IN THIS COLUMN. GO TO NEXT PREGNANCY.	Miscarriage . 01 Abortion. . . 02 Tubal pregnancy . 03 LINE THROUGH Qs. B-4. THROUGH B-15. IN THIS COLUMN. GO TO NEXT PREGNANCY.
Yes . . . . . 01 No. 02 (B-5.)	Yes . . . . . 01 No. 02 (B-5.)	Yes . . . . . 01 No. 02 (B-5.)
Weeks OR Months	Weeks OR Months	Weeks OR Months
Single . . 01 Twins. . . 02 Triplets . 03 CONTINUE IN THIS COLUMN FOR FIRST-BORN BABY. COMPLETE MULTIPLE BIRTH RECORD FOR OTHER BABY(IES).	Single . . 01 Twins. . . 02 Triplets . 03 CONTINUE IN THIS COLUMN FOR FIRST-BORN BABY. COMPLETE MULTIPLE BIRTH RECORD FOR OTHER BABY(IES).	Single . . 01 Twins. . . 02 Triplets . 03 CONTINUE IN THIS COLUMN FOR FIRST-BORN BABY. COMPLETE MULTIPLE BIRTH RECORD FOR OTHER BABY(IES).
Live birth . . 01 Stillbirth . . 02 → LINE THROUGH Qs. B-7. THROUGH B-15. IN THIS COLUMN. GO TO NEXT PREGNANCY.	Live birth . . 01 Stillbirth . . 02 → LINE THROUGH Qs. B-7. THROUGH B-15 IN THIS COLUMN. GO TO NEXT PREGNANCY.	Live birth . . 01 Stillbirth . . 02 → LINE THROUGH Qs. B-7. THROUGH B-15 IN THIS COLUMN. GO TO NEXT PREGNANCY.
Boy . . . . . 01 Girl. 02	Boy . . . . . 01 Girl. 02	Boy . . . . . 01 Girl. 02

		PREGNANCY #1
B-8.	What did you name [him/her]?	
B-9.	How much did (CHILD) weigh when [he/she] was born?	☐☐ Pounds AND ☐☐ Ounces
B-10.	Was (CHILD) delivered by Caesarean section?	Yes . . . . . 01 No. 02
B-11.	HAND CARD A. Did you have any of these illnesses or complications during this pregnancy?	Yes . . . . . 01 No. 02 (B-12.)
	A. Which ones? CIRCLE ALL MENTIONED.	Toxemia . . . . . 01 High blood pressure . . . 02 Edema . . . . . 03 Diabetes, abnormal sugar (glucose) test. . . . . 04 Bladder/kidney infection. 05 Bleeding or heavy spotting. . . . . 06 Epilepsy. . . . . 07 Excess amniotic fluid (polyhydramnios). . . . 08 Heart disease 09
B-12.	Is (CHILD) still living?	Yes . . . . . 01 (B-13.) No. 02
	A. How old was (CHILD) when [he/she] died?	☐☐ Months OR ☐☐ Years
	B. What caused [his/her] death? RECORD VERBATIM.	_____ _____ _____
		LINE THROUGH Qs. B-13. THROUGH B-15. IN THIS COLUMN. GO TO NEXT PREGNANCY.

PREGNANCY #2	PREGNANCY #3	PREGNANCY #4
☐☐ Pounds AND ☐☐ Ounces	☐☐ Pounds AND ☐☐ Ounces	☐☐ Pounds AND ☐☐ Ounces
Yes . . . . . 01 No. 02	Yes . . . . . 01 No. 02	Yes . . . . . 01 No. 02
Yes . . . . . 01 No. 02 (B-12.)	Yes . . . . . 01 No. 02 (B-12.)	Yes . . . . . 01 No. 02 (B-12.)
Toxemia . . . . . 01 High blood pressure . . . 02 Edema . . . . . 03 Diabetes, abnormal sugar (glucose) test. . . . . 04 Bladder/kidney infection. 05 Bleeding or heavy spotting. . . . . 06 Epilepsy. . . . . 07 Excess amniotic fluid (polyhydramnios). . . . 08 Heart disease 09	Toxemia . . . . . 01 High blood pressure . . . 02 Edema . . . . . 03 Diabetes, abnormal sugar (glucose) test. . . . . 04 Bladder/kidney infection. 05 Bleeding or heavy spotting. . . . . 06 Epilepsy. . . . . 07 Excess amniotic fluid (polyhydramnios). . . . 08 Heart disease 09	Toxemia . . . . . 01 High blood pressure . . . 02 Edema . . . . . 03 Diabetes, abnormal sugar (glucose) test. . . . . 04 Bladder/kidney infection. 05 Bleeding or heavy spotting. . . . . 06 Epilepsy. . . . . 07 Excess amniotic fluid (polyhydramnios). . . . 08 Heart disease 09
Yes . . . . . 01 (B-13.) No. 02	Yes . . . . . 01 (B-13.) No. 02	Yes . . . . . 01 (B-13.) No. 02
☐☐ Months OR ☐☐ Years	☐☐ Months OR ☐☐ Years	☐☐ Months OR ☐☐ Years
_____ _____ _____ LINE THROUGH Qs. B-13. THROUGH B-15. IN THIS COLUMN. GO TO NEXT PREGNANCY.	_____ _____ _____ LINE THROUGH Qs. B-13. THROUGH B-15. IN THIS COLUMN. GO TO NEXT PREGNANCY.	_____ _____ _____ LINE THROUGH Qs. B-13. THROUGH B-15. IN THIS COLUNN. GO TO NEXT PREGNANCY.

		PREGNANCY #1
B-13.	Did (CHILD) have a birth defect or other serious health problem when [he/she] was born?	Yes . . . . . 01 No. 02 (B-14.)
	A. What kind of birth defect or health problem? RECORD VERBATIM.	_____ _____ _____ _____
B-14.	Were you enrolled in the WIC program at any time during the year after (CHILD) was born?	Yes . . . . . 01 No. 02 (B-15.)
	A. How many weeks or months did you receive WIC services during the year after (CHILD) was born?	☐☐ Weeks OR ☐☐ Months
B-15.	Has (CHILD) ever been enrolled in the WIC program?	Yes . . 01 No. . . 02 (NEXT PREGNANCY.)
	A. How old was (CHILD) when [he/she] first entered the WIC program?	At birth . . . . . 00 ☐☐ Months OR ☐☐ Years
	B. How old was (CHILD) when [he/she] stopped getting WIC services?	Still in WIC. . . . . 00 ☐☐ Months OR ☐☐ Years
	C. Were there any periods during this time when (CHILD) did not get WIC services?	Yes . . . . . 01 No. . . . . 02 (NEXT Don't know. . DK PREGNANCY.)
	D. How many months altogether did (CHILD) not get WIC services?	☐☐ Months Don't know. . . . DK
	E. How old was (CHILD) when [he/she] started getting WIC services the last time?	☐☐ Months OR ☐☐ Years (NEXT PREGNANCY.)

IF MORE THAN 4 PREGNANCIES GO TO CONTINUATION SECTION.

AFTER ALL PREGNANCIES HAVE BEEN ASKED ABOUT, GO TO SECTION C, PAGE 28.

PREGNANCY #2	PREGNANCY #3	PREGNANCY #4
Yes . . . . . 01 No. 02 (B-14.)	Yes . . . . . 01 No. 02 (B-14.)	Yes . . . . . 01 No. 02 (B-14.)
_____ _____ _____ _____	_____ _____ _____ _____	_____ _____ _____ _____
Yes . . . . . 01 No. 02 (B-15.)	Yes . . . . . 01 No. 02 (B-15.)	Yes . . . . . 01 No. 02 (B-15.)
☐☐ Weeks OR ☐☐ Months	☐☐ Weeks OR ☐☐ Months	☐☐ Weeks OR ☐☐ Months
Yes . . 01 No. . . 02 (NEXT PREGNANCY.)	Yes . . 01 No. . . 02 (NEXT PREGNANCY.)	Yes . . 01 No. . . 02 (NEXT PREGNANCY.)
At birth . . . . . 00 ☐☐ Months OR ☐☐ Years	At birth . . . . . 00 ☐☐ Months OR ☐☐ Years	At birth . . . . . 00 ☐☐ Months OR ☐☐ Years
Still in WIC. . . . . 00 ☐☐ Months OR ☐☐ Years	Still in WIC. . . . . 00 ☐☐ Months OR ☐☐ Years	Still in WIC . . . . . 00 ☐☐ Months OR ☐☐ Years
Yes . . . . . 01 No. . . . . 02 } (NEXT Don't know. . DK } PREGNANCY.)	Yes . . . . . 01 No. . . . . 02 } (NEXT Don't know. . DK } PREGNANCY.)	Yes . . . . . 01 No. . . . . 02 } (NEXT Don't know. . DK } PREGNANCY.)
☐☐ Months Don't know. . . . DK	☐☐ Months Don't know. . . . DK	☐☐ Months Don't know. . . . DK
☐☐ Months OR ☐☐ Years (NEXT PREGNANCY.)	☐☐ Months OR ☐☐ Years (NEXT PREGNANCY.)	☐☐ Months OR ☐☐ Years (NEXT PREGNANCY.)

MULTIPLE BIRTH RECORD

ENTER PREGNANCY NUMBER FROM ORIGINAL PREGNANCY COLUMN.		PREGNANCY # ☐☐
MB-1.	Was the baby born [second/third] a live birth or a stillbirth?	Livebirth . . . . 01 Stillbirth. . . . 02 → LINE THROUGH Qs. MB-2 THROUGH MB-7 IN THIS COLUMN. GO TO INSTRUCTION BOX.
MB-2.	Was this baby a boy or a girl?	Boy . . . . . 01 Girl. 02
MB-3.	What did you name [him/her]?	
MB-4.	How much did (CHILD) weigh when [he/she] was born?	☐☐ Pounds AND ☐☐ Ounces
MB-5.	Is (CHILD) still living?	Yes . . . . . 01 (MB-6.) No. 02
	A. How old was (CHILD) when [he/she] died?	☐☐ Months OR ☐☐ Years
	B. What caused [his/her] death? RECORD VERBATIM.	_____ _____ _____ _____ (LINE THROUGH Qs. MB-6 THROUGH MB-7 IN THIS COLUMN. GO TO INSTRUCTION BOX.)
MB-6.	Did (CHILD) have a birth defect or other serious health problem when [he/she] was born?	Yes . . . . . 01 No. 02 (MB-7.)
	A. What kind of birth defect or health problem? RECORD VERBATIM.	_____ _____ _____ _____

PREGNANCY # ☐	PREGNANCY # ☐	PREGNANCY # ☐
Livebirth . . . . 01 Stillbirth. . . . 02 → LINE THROUGH Qs. MB-2 THROUGH MB-7 IN THIS COLUMN. GO TO INSTRUCTION BOX.	Livebirth . . . . 01 Stillbirth. . . . 02 → LINE THROUGH Qs. MB-2 THROUGH MB-7 IN THIS COLUMN. GO TO INSTRUCTION BOX.	Livebirth . . . . 01 Stillbirth. . . . 02 → LINE THROUGH Qs. MB-2 THROUGH MB-7 IN THIS COLUMN. GO TO INSTRUCTION BOX.
Boy . . . . . 01 Girl. 02	Boy . . . . . 01 Girl. 02	Boy . . . . . 01 Girl. 02
☐☐ Pounds AND ☐☐ Ounces	☐☐ Pounds AND ☐☐ Ounces	☐☐ Pounds AND ☐☐ Ounces
Yes . . . . . 01 (MB-6.) No. 02	Yes . . . . . 01 (MB-6.) No. 02	Yes . . . . . 01 (MB-6.) No. 02
☐☐ Months OR ☐☐ Years	☐☐ Months OR ☐☐ Years	☐☐ Months OR ☐☐ Years
_____ _____ _____ _____ (LINE THROUGH Qs. MB-6 THROUGH MB-7 IN THIS COLUMN. GO TO INSTRUCTION BOX.)	_____ _____ _____ _____ (LINE THROUGH Qs. MB-6 THROUGH MB-7 IN THIS COLUMN. GO TO INSTRUCTION BOX.)	_____ _____ _____ _____ (LINE THROUGH Qs. MB-6 THROUGH MB-7 IN THIS COLUMN. GO TO INSTRUCTION BOX.)
Yes . . . . . 01 No. 02 (MB-7.)	Yes . . . . . 01 No. 02 (MB-7.)	Yes . . . . . 01 No. 02 (MB-7.)
_____ _____ _____ _____	_____ _____ _____ _____	_____ _____ _____ _____

		PREGNANCY # ☐
MB-7.	Has (CHILD) ever been enrolled in the WIC program?	Yes . . . . 01 No. . . . . 02 (INSTRUCTION BOX.)
	A. How old was (CHILD) when [he/she] first entered the WIC program?	At birth . . . . 00 ☐☐ Months
	B. How old was (CHILD) when [he/she] stopped getting WIC services?	Still in WIC . . 00 ☐☐ Months
	C. Were there any periods during this time when (CHILD) did not get WIC services?	Yes . . . . 01 No. . . . . 02 Don't know. DK (INSTRUCTION BOX.)
	D. How many months altogether did (CHILD) not get WIC services?	☐☐ Months Don't know. . . . . DK
	E. How old was (CHILD) when [he/she] started getting WIC services the last time?	☐☐ Months OR ☐☐ Years (INSTRUCTION BOX.)

INSTRUCTION BOX

CHECK Q. B-5. IN THE ORIGINAL PREGNANCY COLUMN WHERE THIS MULTIPLE BIRTH WAS REPORTED. IF TWINS CODED, GO TO Q. B.1 FOR NEXT PREGNANCY. IF TRIPLETS, REPEAT MULTIPLE BIRTH RECORD FOR THIRD BABY. THEN GO TO Q.B.1 FOR NEXT PREGNANCY

PREGNANCY # ☐	PREGNANCY # ☐	PREGNANCY # ☐
Yes . . . . 01 No. . . . . 02 (INSTRUCTION BOX.)	Yes . . . . 01 No. . . . . 02 (INSTRUCTION BOX.)	Yes . . . . 01 No. . . . . 02 (INSTRUCTION BOX.)
At birth . . . . 00 ☐☐ Months	At birth . . . . 00 ☐☐ Months	At birth . . . . 00 ☐☐ Months
Still in WIC . . 00 ☐☐ Months	Still in WIC . . 00 ☐☐ Months	Still in WIC . . 00 ☐☐ Months
Yes . . . . 01 No. . . . . 02 } (INSTRUCTION Don't know. DK } BOX.)	Yes . . . . 01 No. . . . . 02 } (INSTRUCTION Don't know. DK } BOX.)	Yes . . . . 01 No. . . . . 02 } (INSTRUCTION Don't know. DK } BOX.)
☐☐ Months Don't know. . . . . DK	☐☐ Months Don't know. . . . . DK	☐☐ Months Don't know. . . . . DK
☐☐ OR ☐☐ Months Years (INSTRUCTION BOX.)	☐☐ OR ☐☐ Months Years (INSTRUCTION BOX.)	☐☐ OR ☐☐ Months Years (INSTRUCTION BOX.)

C. BACKGROUND INFORMATION

Now I have some general questions about your activities and experiences.

C-1. In what state or country were you born?

State _____

Country _____

C-2. Are you presently married, widowed, divorced, separated, or have you never been married?

Married. 01
Widowed. 02
Divorced 03
Separated. 04
Never married. 05

C-3. What is the highest grade of school or year of college that you have completed?

(CIRCLE ONE.)

None . . . . . 00 ⟶ (C-4.)
Elementary . . . 01 02 03 04 05 06 07 08
High school. . . 09 10 11 12
College. . . . . 13 14 15 16 17+ ⟶ (C-4.)

A. Did you get a high school diploma or pass a high school equivalency test?

Yes 01
No. 02

C-4. Have you <u>ever</u> worked for pay at a full- or part-time job?

Yes. 01
No 02 (C-5.)

A. What has been your usual occupation during the time that you have worked?

_____

B. What kind of business or industry was that in?

_____

C. What were your most frequent activities or duties in this occupation?

_____

C-4. D. HAND CARD B. This card divides jobs into 11 groups and gives examples of jobs in each group. Please tell me the number of the group that best describes your usual occupation.

(CIRCLE ONE.)

Operated farms	01
Farm worker	02
Heavy physical worker	03
Service worker	04
Operated or serviced vehicles	05
Helped manufacture or process things	06
Practiced skilled trades or crafts	07
Office or clerical work	08
Sold things	09
Manager or administrator	10
Professional or technical specialties	11

C-5. Are you currently (working for pay either full-time or part-time, or are you) unemployed, a housewife, a student, or what?

(CIRCLE ONE.)

Working	01	
Temporarily laid off	02	(C-6.)
Unemployed	03	(C-6.)
Permanently disabled	04	(C-6.)
Housewife	05	(C-6.)
Student	06	(C-6.)
Other (SPECIFY)	07	(C-6.)

_____

_____

A. How many hours a week do you usually work?

☐☐ Hours

B. Does your present job require heavy physical work, moderate physical work, or little or no physical work?

Heavy physical work	01
Moderate physical work	02
Little or no physical work	03

C. At your present job, do you spend most, part, little, or none of the time standing on your feet?

Most	01
Part	02
Little	03
None	04

C-6. My next questions are about the father of the baby you are expecting. What is the highest grade of school or year of college that he has completed?

(CIRCLE ONE.)

None	00 → (C-7.)							
Elementary	01	02	03	04	05	06	07	08
High school.	09	10	11	12				
College.	13	14	15	16	17+ → (C-7.)			

A. Did he get a high school diploma or pass a high school equivalency test?

Yes 01
No. 02

C-7. Has he ever worked for pay at a full- or part-time job?

Yes 01
No. 02 (C-8.)

A. What has been his usual occupation during the time that he has worked?

_____

B. What kind of business or industry was that in?

_____

C. What were his most frequent activities or duties in this occupation?

_____

D. HAND CARD B. This card divides jobs into 11 groups and gives examples of jobs in each group. Please tell me the number of the group that best describes his usual occupation.

(CIRCLE ONE.)

Operated farms. 01
Farm worker 02
Heavy physical worker 03
Service worker. 04
Operated or serviced vehicles 05
Helped manufacture or process things. . 06
Practiced skilled trades or crafts. . . 07
Office or clerical work 08
Sold things 09
Manager or administrator. 10
Professional or technical specialties . 11

C-8. Is he currently (working for pay either full-time or part-time, or is he) unemployed, a student, or what?

(CIRCLE ONE.)

Working. 01
Temporarily laid off 02
Unemployed 03
Permanently disabled 04
Student. 05
Other (SPECIFY). 06

_____

_____

C-9. Are you currently living with the baby's father?

Yes. 01
No 02

C-10. Are any languages other than English spoken in your home?

Yes. 01
No . . . . . 02 (HOUSEHOLD ROSTER.)

A. What language other than English is spoken most often in your home?

(CIRCLE ONE.)

Chinese 01
French. 02
German. 03
Italian 04
Portugese 05
Spanish 06
Vietnamese. 07
Other (SPECIFY) 08

_____

HOUSEHOLD ROSTER AND
SAMPLE CHILD SELECTION

- UNFOLD ROSTER FLAP FROM BACK COVER.

- ENTER RESPONDENT'S NAME ON TOP LINE OF ROSTER. ASK BIRTHDATE; VERIFY AGE AND RECORD.

- REFER TO CHECKPOINT B ON PAGE 17. HAS RESPONDENT HAD ANY PREVIOUS PREGNANCIES?

☐ YES → REFER TO Q. B-12 IN EACH PREGNANCY COLUMN.
DOES RESPONDENT HAVE ANY LIVING CHILDREN?

☐ YES → Q. HR-1.

☐ NO → Q. HR-3.

☐ NO → Q. HR-3.

HR-1. Do you have any children of your own under 5 years of age who live with you now?

Yes. 01
No 02 (HR-2.)

A. Let's list them in order of age, beginning with the oldest child who is under 5. What are their names? ENTER NAMES IN SECTION A OF ROSTER.

ASK B-D FOR EACH CHILD LISTED.

B. (ASK IF NOT APPARENT:) How is (NAME) related to you?
ENTER RELATIONSHIP TO RESPONDENT BESIDE NAME.

C. CODE SEX, M OR F, BESIDE NAME IN ROSTER.

D. What is (NAME'S) date of birth?
ENTER BESIDE NAME IN ROSTER; VERIFY AGE AND RECORD.

ASK E FOR ALL CHILDREN UNDER 5 IN ROSTER.

E. Does all or part of the money to pay for [this child's/these children's] food expenses come from you or someone related to you in your household?

Yes . . . 01 → ASSIGN FAMILY UNIT CODE 1 BESIDE EACH CHILD'S NAME.

No. . . . 02 → DETERMINE WHICH CHILDREN ARE IN FAMILY FOOD EXPENSE UNIT. ASSIGN FAMILY UNIT STATUS CODE 1 BESIDE THEIR NAMES.

ASSIGN FAMILY UNIT STATUS CODE 2 BESIDE NAMES OF CHILDREN WHO ARE NOT IN FAMILY FOOD EXPENSE UNIT.

HR-2. Do you have any children of your own between 5 and 18 years old who live with you now?

Yes 01
No 02 (HR-3.)

A. Let's list them in order of age, beginning with the oldest child who is 18 or under. What are their names? ENTER NAMES IN SECTION B OF ROSTER.

ASK B-D FOR EACH CHILD LISTED.

B. (ASK IF NOT APPARENT:) How is (NAME) related to you?
ENTER RELATIONSHIP TO RESPONDENT BESIDE NAME.

C. CODE SEX, M OR F, BESIDE NAME IN ROSTER.

D. What is (NAME'S) date of birth?
ENTER BESIDE NAME IN ROSTER; VERIFY AGE AND RECORD.

ASK E FOR ALL CHILDREN 5-18 IN ROSTER.

E. Does all or part of the money to pay for [this child's/these children's] food expenses come from you or someone related to you in your household?

Yes . . . 01 → ASSIGN FAMILY UNIT CODE 1 BESIDE EACH CHILD'S NAME.
No. . . . 02 → DETERMINE WHICH CHILDREN ARE IN FAMILY FOOD EXPENSE UNIT. ASSIGN FAMILY UNIT STATUS CODE 1 BESIDE THEIR NAMES.

ASSIGN FAMILY UNIT STATUS CODE 2 BESIDE NAMES OF CHILDREN WHO ARE NOT IN FAMILY FOOD EXPENSE UNIT.

HR-3. Now I need to know about any (other) children and all adults who regularly live in your household. Are there any (other) children or adults who regularly live in your household?

Yes. 01
No . . . . . 02 (SAMPLE CHILD PROCEDURE.)

A. Let's list them in order of age, beginning with the oldest. What are their names? ENTER NAMES IN SECTION C OF ROSTER.

ASK B-D FOR EACH PERSON LISTED.

B. How is (NAME) related to you?
ENTER RELATIONSHIP TO RESPONDENT BESIDE NAME.

C. (ASK IF NOT APPARENT:) Is (NAME) male or female?
CODE SEX, M OR F, BESIDE NAME IN ROSTER.

D. What is (NAME'S) date of birth?
ENTER BESIDE NAME IN ROSTER; VERIFY AGE AND RECORD.

ASK E FOR ALL PERSONS LISTED IN SECTION C OF ROSTER.

E. Does all or part of the money to pay for [this person's/these persons'] food expenses come from you or someone related to you in the household?

Yes . . . 01 → ASSIGN FAMILY UNIT CODE 1 BESIDE EACH PERSON'S NAME.

No. . . . 02 → DETERMINE WHICH PERSONS ARE IN FAMILY FOOD EXPENSE UNIT. ASSIGN FAMILY UNIT STATUS CODE 1 BESIDE THEIR NAMES.

ASSIGN FAMILY UNIT STATUS CODE 2 BESIDE NAMES OF PERSONS WHO ARE NOT IN FAMILY FOOD EXPENSE UNIT.

SAMPLE CHILD SELECTION

SC-1. REVIEW SECTION A OF ROSTER. ARE ANY CHILDREN UNDER 5 YEARS OLD LISTED?

Yes. . . . . 01 → (SC-2.)
No . . . . . 02 → (SECTION D.)

SC-2. SELECT SAMPLE CHILD 0-4 YEARS OLD, BASED ON RANDOM NUMBERS ON "SAMPLE CHILD PACKAGE" LABEL ON ACF. CIRCLE LINE NUMBER OF SAMPLE CHILD IN ROSTER.

TELL RESPONDENT THAT YOU WILL WANT TO GET SOME INFORMATION ABOUT THE SAMPLE CHILD AND ANY OTHER ELIGIBLE 4- OR 5-YEAR-OLD CHILDREN.

IF RESPONDENT HAS TIME DURING THIS VISIT, COMPLETE CONSENT FORM AND DIETARY INTERVIEW FOR SAMPLE CHILD AFTER YOU COMPLETE THIS INTERVIEW AND MEASUREMENTS.

IF RESPONDENT'S TIME IS LIMITED, COMPLETE THIS INTERVIEW AND MEASUREMENTS NOW. SCHEDULE AN APPOINTMENT FOR A HOME VISIT TO COMPLETE ALL CHILD(REN)'S DATA COLLECTION.

D. INCOME

My next questions are about family income received from all sources last month. (As we talk about family income, please include income earned or received by all of the people who lived in your household during (LAST MONTH).)

D-1. Did you (or any members of your household) receive wages, salary, commissions, bonuses, or tips from jobs during (LAST MONTH)?

Yes 01
No 02 (D-2.)

A. Altogether, how much did [you/all members of your household] receive, before taxes, from wages, salary, commissions, bonuses, or tips during (LAST MONTH)?

USE THIS SPACE FOR CALCULATIONS

$ ☐☐☐☐ Wages, etc.

D-2. Did you (or any members of your household) receive any payments in (LAST MONTH) from...

			ASK FOR EACH SOURCE CODED "YES": What was the total amount of that payment?
A.	Supplemental Security Income or SSI?	Yes . . . 01 → No. . . . 02 (B.)	$ ☐☐☐☐
B.	Aid to Families with Dependent Children or AFDC?	Yes . . . 01 → No. . . . 02 (C.)	$ ☐☐☐☐
C.	Any other public assistance or welfare program?	Yes . . . 01 → No. . . . 02 (D-3.)	$ ☐☐☐☐

D-3. During (LAST MONTH), did you (or any members of your household) receive...

			ASK FOR EACH SOURCE CODED "YES": What was the total amount of that payment?
A.	Any Unemployment Insurance?	Yes . . . 01 → No. . . . 02 (B.)	$ ☐☐☐☐
B.	Any Workers' Compensation?	Yes . . . 01 → No. . . . 02 (C.)	$ ☐☐☐☐
C.	Any Social Security or Railroad Retirement benefits?	Yes . . . 01 → No. . . . 02 (D.)	$ ☐☐☐☐
D.	Any money from a pension, retirement fund, or annuity?	Yes . . . 01 → No. . . . 02 (E.)	$ ☐☐☐☐
E.	Any child support, alimony, or other regular cash payments?	Yes . . . 01 → No. . . . 02 (F.)	$ ☐☐☐☐
F.	Any interest payments, dividends, or rental income?	Yes . . . 01 → No. . . . 02 (G.)	$ ☐☐☐☐
G.	Any income from any other sources, such as money from insurance settlements, education loans, or gifts?	Yes . . . 01 → No. . . . 02 (D-4.)	$ ☐☐☐☐

D-4. Was the total income that [you/your household] received in (LAST MONTH) more than, less than, or about the same as your <u>usual</u> monthly income?

More 01
Less 02
About the same 03

D-5. HAND CARD C. Please look at the income groups on this card and tell me the number of the group that comes closest to your (household's) total income, before taxes, in 1982. Remember to consider income from all sources (and income received by all members of your household) during 1982.

PER MONTH	PER YEAR	
Under $83	Under $1,000	01
$83 to $166	$1,000 to $1,999	02
$167 to $249	$2,000 to $2,999	03
$250 to $416	$3,000 to $4,999	04
$417 to $582	$5,000 to $6,999	05
$583 to $832	$7,000 to $9,999	06
$833 to $1,082	$10,000 to $12,999	07
$1,083 to $1,332	$13,000 to $15,999	08
$1,333 or more	$16,000 or more	09

(THIS PAGE IS INTENTIONALLY BLANK.)

E. FAMILY FOOD EXPENDITURES

E-1. The next questions are about your usual food expenses. (I will use the term "family unit" to indicate the person or group of persons in your household who share(s) responsibility for certain major expenses, such as food. The person(s) I'm including in your family unit are you and (NAMES OF ALL PERSONS IN HOUSEHOLD ROSTER WITH FAMILY UNIT STATUS CODE "1").)

Were you (or any members of your family unit) away from home overnight or longer, for one day or more, during the past month?

Yes 01
No 02 (E-2.)

A. Which person(s)? ENTER FIRST NAMES IN TABLE.

B. How many nights in all was (NAME) away during the past month? ENTER NUMBER OF NIGHTS AWAY FOR EACH PERSON.

NAME	NIGHTS AWAY

E-2. Did any visitors or guests stay with you overnight or longer (for one day or more) during the past month, not counting people who usually live here?

Yes 01
No 02 (E-3.)

A. How many such persons? ENTER NUMBER OF PERSONS FOR EACH VISIT.

B. How many nights did they stay? ENTER NUMBER OF NIGHTS FOR EACH VISIT.

	NUMBER OF PERSONS	NUMBER OF NIGHTS
VISIT 1		
VISIT 2		
VISIT 3		
VISIT 4		
VISIT 5		
VISIT 6		

E-3. Now I have some questions about the amount of money you (and your family unit) spend for food. First, think about all the times that you (or other members of your family unit) shopped at a grocery store or supermarket during the past month.
During the past month, what was the total amount of your (family unit's) purchases at the grocery store or supermarket? Include purchases made with food stamps, WIC vouchers, or benefits from other food programs.

$ ___

None. 00 (E-4.)

A. About how much of this amount was for non-food items, such as paper products, detergents, home cleaning supplies, pet foods, and alcoholic beverages?

$ ___

B. Is (AMOUNT IN E-3.) about what you usually spend per month at the grocery store or supermarket?

Yes 01 (E-4.)
No. 02

C. What would you say is a more typical figure?

$ ___

E-4. During the past month have you (or any members of your family unit) purchased any food or nonalcoholic beverages from places other than grocery stores, such as convenience stores, dairy stores, specialty stores, bakeries, vegetable stands, farmers' markets, or home delivery? Include any large purchases made for freezing or canning.

Yes. 01
No 02 (E-5.)

A. What was your (family unit's) total monthly expense at these places excluding purchases of non-food items and alcoholic beverages?

$ ___

E-5. During the past month, have you (or any members of your family unit) bought any meals or snacks in restaurants, cafeterias, cafes, drive-ins, vending machines, or other such places?

Yes. 01
No 02 (E-6.)

A. What was the total amount spent for these purchases during the past month, not counting beer, wines, and other alcoholic beverages?

$ ___

E-6. During the past month, have you (or any members of your family unit) made any large or bulk purchases of meat, fruit, or vegetables for home freezing or canning?

Yes. 01
No 02 (E-7.)

A. What was the total cost, including charges for cutting, wrapping, and freezing?

$ [| |]

B. Have you eaten any of that food yet?

Yes 01
No. 02 (E-7.)

C. About how much of that food did you eat during the past month? Would you say half of it (50%), a third (33%), one-fourth (25%), 10 percent, or what?

[| |] %

E-7. (Other than last month) during the past <u>six</u> months, have you (or any members of your family unit) made any large or bulk purchases of meat, fruit, or vegetables for home freezing or canning?

Yes. 01
No 02 (E-8.)

A. What was the total cost of that food, including charges for cutting, wrapping, and freezing?

$ [| |]

B. Have you eaten any of that food yet?

Yes 01
No. 02 (E-8.)

C. About how much of that food did you eat during the past month? Would you say half of it (50%), a third (33%), one-fourth (25%), 10 percent, or what?

[| |] %

E-8. During the past month, have you (or any members of your family unit) eaten any fresh, frozen, or canned food that you raised yourself or that was raised by a friend or relative?

Yes 01
No 02 (E-9.)

A. About how much would this food have cost if you bought it in a store?

$ ☐☐☐

E-9. Now I would like to talk to you about assistance you (or any members of your family unit) may have received from various food programs during the past month. First, during the past month, have you (or any members of your family unit) received any Federal Food Stamps?

Yes 01
No. 02 (E-10.)

A. What was the value of all food stamps received last month?

$ ☐☐☐

IF RESPONDENT IS ONLY FAMILY UNIT MEMBER, GO TO CHECKPOINT C.

E-10. During the past month, have any members of your family unit, not counting yourself, received any benefits or services from the WIC Program--the Special Food Program for Women, Infants, and Children?

Yes 01
No. 02 (E-11.)

A. (IF ANY IN FAMILY UNIT): During the past month, how many women in your family unit, not counting yourself, received benefits or services from the WIC Program? IF NONE, ENTER 00.

☐☐ Women

B. (IF ANY IN FAMILY UNIT): And how many infants 3 months old or younger received such benefits or services? IF NONE, ENTER 00.

☐☐ Infants (3 mos. or younger)

C. (IF ANY IN FAMILY UNIT): How many infants 4 months to 1 year old (received such benefits or services)? IF NONE, ENTER 00.

☐☐ Infants (4 mos. to 1 year)

D. (IF ANY IN FAMILY UNIT): How many children between 1 and 5 years old (received such benefits or services)? IF NONE, ENTER 00.

☐☐ Children (1 to 5 years)

E-11. (Not counting yourself,) is there anyone in your family unit who has applied for WIC services but has not yet received them?

Yes 01
No . . . . . 02 (CHECKPOINT C.)

A. Who is that? ENTER NAME AND RELATIONSHIP TO RESPONDENT IN TABLE.

B. Why has (NAME) not yet received WIC services? CODE REASON BY NAME.

NAME	RELATIONSHIP TO RESPONDENT	REASON		
		INELIGIBLE	WAITING LIST	OTHER
(1)		01	02	03 (SPECIFY) _____ _____
(2)		01	02	03 (SPECIFY) _____ _____
(3)		01	02	03 (SPECIFY) _____ _____
(4)		01	02	03 (SPECIFY) _____ _____

CHECKPOINT C

ARE ANY FAMILY UNIT MEMBERS 18 YEARS OLD OR YOUNGER?

☐ YES → Q. E-12.

☐ NO → Q. E-15.

E-12. During the past month, have (you or) any children in your family unit purchased, or received free, any meals at school, or in a day-care, Head Start, kindergarten, or other preschool program?

Yes 01
No 02 (E-13.)

A. What are the first names of the children who purchased, or received free, meals at school or in a preschool program? ENTER THE NAME OF EACH CHILD PURCHASING OR RECEIVING MEALS AT SCHOOL IN COLUMN 1 OF TABLE AND CIRCLE "C" IN COLUMN 2 FOR EACH NAME ENTERED.

E-13. ASK ONLY IF ALL PEOPLE 18 OR UNDER ARE NOT LISTED IN TABLE. During the school year, do (you or) any (other) children in your family unit usually purchase, or receive free, any meals at school, or in a daycare, Head Start, kindergarten, or other preschool program?

Yes 01
No . . . . . 02 (CHECKPOINT D.)

A. What are the first names of the children who usually purchase, or receive free, meals at school or in a preschool program? ENTER THE NAME OF EACH CHILD PURCHASING OR RECEIVING MEALS AT SCHOOL IN COLUMN 1 OF TABLE AND CIRCLE "U" IN COLUMN 2 FOR EACH NAME ENTERED.

CHECKPOINT D

ARE ANY NAMES LISTED IN TABLE?

☐ YES → Q. E-14.

☐ NO → Q. E-15.

E-14. ASK Qs. A-C FOR EACH CHILD LISTED IN TABLE.

A. On average, about how many meals per week did (NAME) (usually) purchase or receive at school or preschool (during the past month)? ENTER NUMBER OF MEALS IN COLUMN 3 BESIDE NAME.

B. What was the usual weekly expense for the meals (NAME) purchased or received at school or preschool? ENTER AMOUNT IN COLUMN 4 BESIDE NAME. IF MEALS ARE FREE, ENTER 00.

C. And where did (NAME) usually eat those meals--at (elementary or high) school or in a preschool program? CIRCLE NUMBER CORRESPONDING TO TYPE OF SCHOOL IN COLUMN 5 BESIDE NAME.

1	2	3	4	5
NAME OF CHILD	CURRENTLY OR USUALLY RECEIVE?	AVERAGE NO. OF MEALS PER WEEK	USUAL WEEKLY EXPENSE	TYPE OF SCHOOL: 1 = GRADE OR HIGH SCHOOL 2 = PRESCHOOL
	C U	☐☐	$ ☐☐	1 2
	C U	☐☐	$ ☐☐	1 2
	C U	☐☐	$ ☐☐	1 2
	C U	☐☐	$ ☐☐	1 2
	C U	☐☐	$ ☐☐	1 2
	C U	☐☐	$ ☐☐	1 2
	C U	☐☐	$ ☐☐	1 2
	C U	☐☐	$ ☐☐	1 2

E-15. Finally, during the past month, have you (or any members of your family unit) received any free food, beverages, or meals through public or private welfare agencies, including religious organizations? (DO NOT INCLUDE FREE MEALS IN SCHOOL OR PRESCHOOL PROGRAMS.)

Yes. 01
No . . . . . 02 (SECTION F.)

A. About how much would that food have cost if you had paid for it?

$ ☐☐☐

Don't know. . . . DK

F. LOCATOR INFORMATION

We will want to talk to you again before the end of this pregnancy. Please give me the names and addresses of two people who will always know how to get in touch with you.

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE (_____) _____ RELATIONSHIP _____

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE (_____) _____ RELATIONSHIP _____

G. AUTHORIZATION FORM PROCEDURE

After your baby is born, we would like to get some information from your hospital records. We will use this information to complete our study of the health and nutrition of mothers and their babies.

Let's read this form together. (READ AUTHORIZATION FORM WITH RESPONDENT AND ANSWER QUESTIONS AS NECESSARY.)

I will fill out this form and then you can sign it.

☐ RESPONDENT WILL SIGN.
- PREPARE FORM AND PUT ID LABEL ON IT.
- GIVE FORM TO RESPONDENT TO SIGN.
- RETRIEVE FORM AND KEEP WITH INTERVIEW PACKAGE.

☐ RESPONDENT WILL NOT SIGN.

End Time _____ am
pm

WOMEN'S MEASUREMENT FORM

NAME (FIRST, MIDDLE, LAST)

DATE OF MEASUREMENTS

Month Day Year

1. TYPE OF CLOTHING DURING WEIGHT
   - Gown and slippers 01
   - Light street clothing . . . 02
   - Other (SPECIFY) 03

   _____

2. WEIGHT ☐☐☐ · ☐☐ lb. OR ☐☐☐ · ☐☐ kg.

3. HEIGHT ☐☐ ☐ /8 in. OR ☐☐☐ · ☐ cm.

4. LEFT ARM CIRCUMFERENCE ☐☐ · ☐ cm.

5. LEFT TRICEPS SKINFOLD

   (a) ☐☐ · ☐ mm.
   (b) ☐☐ · ☐ mm.

   IF MEASURES DIFFER BY MORE THAN 3 mm., TAKE THIRD MEASURE.

   (c) ☐☐ · ☐ mm.

6. LEFT SUBSCAPULAR SKINFOLD

   (a) ☐☐ · ☐ mm.
   (b) ☐☐ · ☐ mm.

   IF MEASURES DIFFER BY MORE THAN 3 mm., TAKE THIRD MEASURE.

   (c) ☐☐ · ☐ mm.

7. COMMENTS ON MEASUREMENTS: _____

   _____

   _____

8. A. WEIGHT WAS...
      - Abstracted from record 01
      - Taken by operative 02

   B. HEIGHT WAS...
      - Abstracted from record 01
      - Taken by operative 02

9. ESTIMATE THE TOTAL NUMBER OF MINUTES REQUIRED TO TAKE MEASUREMENTS AND ABSTRACT DATA.

   ☐☐ Minutes

HOUSEHOLD ROSTER

Family Unit Status Code	First Name Last Name	Relationship to Respondent	Sex	Birthdate Mo. Day Year	Age
1		RESPONDENT	(F)		

A. RESPONDENT'S CHILDREN UNDER 5 YEARS OLD

	01		M F		
	02		M F		
	03		M F		
	04		M F		
	05		M F		
	06		M F		

B. RESPONDENT'S CHILDREN 5 to 18 YEARS OLD

			M F		
			M F		
			M F		
			M F		
			M F		
			M F		
			M F		
			M F		

C. OTHER HOUSEHOLD MEMBERS

			M F		
			M F		
			M F		
			M F		
			M F		
			M F		
			M F		

OMB No. 0584-0306
Expires 12/31/83

A Study of
Health and Nutrition of Mothers and Their Children

Sponsored by

Food and Nutrition Service
U.S. Department of Agriculture

Conducted by

New York State Research Foundation
and
Research Triangle Institute

RECORD OF YOUR DAILY FOOD COSTS

PLEASE WRITE DOWN ALL OF YOUR COSTS FOR FOOD AND BEVERAGES DURING THE 7-DAY PERIOD BEGINNING ON

Day _____ Date _____

THROUGH

Day _____ Date _____

ID LABEL

NOTICE--All information which would permit identification of the individual will be held in strict confidence, will be used only by persons engaged in and for the purposes of the survey, and will not be disclosed or released to others for any purposes.

FAMILY UNIT LISTING

Listed below are the members of your family unit who share food costs. During the next 7 days, please write down the cost of all food and beverages that you and any people listed below buy.

If any of the people listed below are away from home overnight or longer during the next 7 days, write in the number of days the person was away from home beside his or her name. For example, if a child spent Saturday and Sunday with a friend, write "2" beside the child's name in the "DAYS AWAY" column.

FAMILY UNIT MEMBERS

FIRST NAME	AGE	DAYS AWAY	FIRST NAME	AGE	DAYS AWAY
1.			9.		
2.			10.		
3.			11.		
4.			12.		
5.			13.		
6.			14.		
7.			15.		
8.			16.		

If any relatives or friends stay overnight in your house, please write their first name and age in the VISITOR BOX below. Then, write in the number of days the visitor(s) stayed in your home.

VISITOR BOX

FIRST NAME	AGE	DAYS IN YOUR HOME

1

HOW TO KEEP THIS RECORD

Use this form to write down the kinds and costs of all food and non-alcoholic beverages that you and any members of your family unit buy during the next 7 days.

There are pages for each day and there are two parts for each day. In Part 1, write down all foods and non-alcoholic beverages bought at grocery stores, supermarkets, convenience stores, bakeries, delicatessens, markets, or other food stores. Include the total cost without tax and mark if the food or drink was fresh, frozen, bottled or canned, or prepared in some other way. The example below shows how to record in Part 1.

FIRST DAY — ENTER DAY > Tuesday

Part 1 — FOOD AND BEVERAGES

Dairy and Bakery Products — Pastry, brownies, bread, milk, cream, eggs, etc.

a LINE NO.	b Food Type (Describe the food purchased, such as whole milk, ground beef, apples, all purpose flour, saltines, etc.)	c Is this food – Mark (X) one: Fresh	Frozen	Bottled or Canned	Other	d Total Cost Include sales tax: Dollars	Cents	OFFICE USE ONLY
001	Eggs	X				$ 1	69	
002	Potato chips				X		89	
003	Diet 7-up			X		1	89	
004	Sausage	X				1	57	
005								

In Part 2, write down all meals, snacks, and beverages bought from restaurants, vending machines, snack bars, school or company cafeterias, and other such places. The example below shows how to record in Part 2.

Part 2 — MEALS, SNACKS, AND BEVERAGES PURCHASED AT A RESTAURANT, CARRY-OUT, ETC.

Breakfasts, dinners, school lunches, vending machine snacks, and drinks purchased at a restaurant, lounge, etc.

a LINE NO.	b List meals, snacks, or beverages purchased away from home	c Total Cost Include tips: Dollars	Cents	d Were alcoholic beverages included in total cost? Mark (X): Yes	No	If YES, How Much? Dollars	Cents	OFFICE USE ONLY
050	Lunch	$ 1	37		X	$		
051	Coffee		30		X			
052	2 school lunches	1	20		X			
053	2 dinners.	12	00	X		2	50	
054								

If there are not enough lines in either Part 1 or Part 2 to write down all foods and beverages bought on a certain day, go to pages 22 through 24 and use the ADDITIONAL PAGES. When you use these ADDITIONAL PAGES, be sure to write in the day on which the food or beverage was bought, as shown below.

ADDITIONAL PAGE FOR PART 1 - FOOD AND BEVERAGES

a	b		c				d		OFFICE USE ONLY	
LINE NO.	Enter Day	Food Type (Describe the food purchased, such as whole milk, ground beef, apples, all purpose flour, saltines, etc.)	Is this food - Mark (X) one: Fresh	Frozen	Bottled or Canned	Other	Total Cost Exclude sales tax: Dollars	Cents	(1)	(2)
001	Monday	Whole wheat bread	1 X	2	3	4	$	89		
002			1	2	3	4	$			
003			1	2	3	4	$			

WHAT TO REPORT

Include...

- Every food or beverage that you or members of your family unit buy during the next 7 days, no matter how little cost is involved. Don't forget soft drinks, candy bars, potato chips, and other snacks.
- Meals, snacks, and beverages bought and eaten away from home.
- Foods bought with food stamps, WIC vouchers, or any other special food programs.

Do not include...

- Food costs of family unit members while they are away from home overnight.
- Any sales tax added to the cost of the food or beverage.
- Any food or beverages that friends or relatives bought for you or members of your family unit.

HOW TO REPORT

Write down the type or brand name of all foods and beverages. Be as specific as possible. For example:

Whole milk
Diet Coca-Cola
Kellogg's Corn Flakes
Spare ribs
Cheddar Cheese Spread

For the foods listed below, be sure to describe them as completely as possible.

MILK - Describe as whole milk, skim milk, 2% milk, condensed milk, evaporated milk, or powdered milk.

BREAD - Describe as white bread, whole wheat bread, rye bread, or other specific type.

BEEF - Describe the type, such as beef ribs, ground beef or hamburger, round steak, or other cut or type.

PORK - Describe the type, such as spare ribs, loin chops, bacon, sausage, fresh ham, smoked ham, or other cut or type.

CHICKEN - Describe as whole chicken or chicken parts, such as legs, wings, breasts, or other pieces.

SOFT DRINKS - Write down the brand name and type, such as Tab, Coca-Cola, Diet 7-Up, Dr. Pepper, Diet Pepsi Cola, Chek Grape Soda, or other brands.

COFFEE - Describe as regular (ground) or instant coffee. Include "freeze-dried" coffee as instant coffee.

Most people find that keeping this record is easiest when they write down the food or beverage and its cost as soon as they get home from the place where they bought the food or beverage.

Every day, you will need to ask all members of your family unit to tell you the type and cost of any food and beverages they have bought. Don't forget to write these foods down on the day they were bought.

Check the Daily Reminder List on the back cover for any food costs you may have forgotten to write down.

IF YOU HAVE PROBLEMS OR QUESTIONS

If you need help or have questions during the next 7 days, please call me collect at the number below.

INTERVIEWER'S NAME	TELEPHONE NUMBER

I will visit you again on _____, _____ to pick up this completed record.

THANK YOU VERY MUCH!

SAMPLE PAGES

INSTRUCTIONS: Use these pages to record the usual types of food costs for this family unit.

Part 1 FOOD AND BEVERAGES	a LINE NO.	b Food Type *(Describe the food purchased, such as whole milk, ground beef, apples, all purpose flour, saltines, etc.)*	c Is this food – *Mark (X) one* Fresh	Frozen	Bottled or Canned	Other	d Total Cost *Exclude sales tax* Dollars	Cents	OFFICE USE ONLY
Dairy and Bakery Products Pastry, brownies, bread, milk, cream, eggs, etc.	001		1	2	3	4	$		
	002		1	2	3	4			
	003		1	2	3	4			
	004		1	2	3	4			
	005		1	2	3	4			
	006		1	2	3	4			
	007		1	2	3	4			
	008		1	2	3	4			
	009		1	2	3	4			
Meat, Fish, and Poultry Beef brisket, trout, chicken parts, etc.	010		1	2	3	4			
	011		1	2	3	4			
	012		1	2	3	4			
	013		1	2	3	4			
	014		1	2	3	4			
	015		1	2	3	4			
Fruits and Vegetables Apples, peaches, apricots, onions, tomatoes, etc.	016		1	2	3	4			
	017		1	2	3	4			
	018		1	2	3	4			
	019		1	2	3	4			
	020		1	2	3	4			
	021		1	2	3	4			
	022		1	2	3	4			
Beverages Juice, gingerale, colas, etc.	023		1	2	3	4			
	024		1	2	3	4			
	025		1	2	3	4			

SAMPLE PAGES

Part 1

FOOD AND BEVERAGES (Continued)

All Other Foods

Cereals, non-dairy whipped cream, flour, sugar, coffee, teabags, macaroni, etc.

a LINE NO.	b Food Type *(Describe the food purchased, such as whole milk, ground beef, apples, all purpose flour, saltines, etc.*	c Is this food – *Mark (X) one* Fresh	Frozen	Bottled or Canned	Other	d Total Cost *Exclude sales tax* Dollars	Cents	OFFICE USE ONLY
026		1	2	3	4	$		
027		1	2	3	4			
028		1	2	3	4			
029		1	2	3	4			
030		1	2	3	4			
031		1	2	3	4			
032		1	2	3	4			
033		1	2	3	4			
034		1	2	3	4			
035		1	2	3	4			
036		1	2	3	4			

Part 2

MEALS, SNACKS, AND BEVERAGES PURCHASED AT A RESTAURANT, CARRY-OUT, ETC.

Breakfasts, dinners, school lunches, vending machine snacks, and drinks purchased at a restaurant, lounge, etc.

a LINE NO.	b List meals, snacks, or beverages purchased away from home	c Total Cost *Include tips* Dollars	Cents	Were alcoholic beverages included in total cost? *Mark (X)* Yes	No	d *IF YES,* How Much? Dollars	Cents	OFFICE USE ONLY
050		$		1	2	$		
051				1	2			
052				1	2			
053				1	2			
054				1	2			
055				1	2			
056				1	2			
057				1	2			
058				1	2			
059				1	2			

IF MORE SPACE IS NEEDED TO WRITE DOWN FOOD AND BEVERAGES OR MEALS, SNACKS, AND BEVERAGES BOUGHT AWAY FROM HOME, GO TO PAGES 22 - 24.

FIRST DAY — ENTER DAY

Part 1

FOOD AND BEVERAGES

	a	b	c				d		OFFICE USE ONLY
	LINE NO.	Food Type *(Describe the food purchased, such as whole milk, ground beef, apples, all purpose flour, saltines, etc.)*	Is this food — *Mark (X) one*				Total Cost *Exclude sales tax*		
			Fresh	Frozen	Bottled or Canned	Other	Dollars	Cents	
Dairy and Bakery Products Pastry, brownies, bread, milk, cream, eggs, etc.	001		1	2	3	4	$		
	002		1	2	3	4			
	003		1	2	3	4			
	004		1	2	3	4			
	005		1	2	3	4			
	006		1	2	3	4			
	007		1	2	3	4			
	008		1	2	3	4			
	009		1	2	3	4			
Meat, Fish, and Poultry Beef brisket, trout, chicken parts, etc.	010		1	2	3	4			
	011		1	2	3	4			
	012		1	2	3	4			
	013		1	2	3	4			
	014		1	2	3	4			
	015		1	2	3	4			
Fruits and Vegetables Apples, peaches, apricots, onions, tomatoes, etc.	016		1	2	3	4			
	017		1	2	3	4			
	018		1	2	3	4			
	019		1	2	3	4			
	020		1	2	3	4			
	021		1	2	3	4			
	022		1	2	3	4			
Beverages Juice, gingerale, colas, etc.	023		1	2	3	4			
	024		1	2	3	4			
	025		1	2	3	4			

FIRST DAY -- CONTINUED

Sun . . 01 Mon . . 02 Tue . . 03 Wed . . 04 Thu . . 05 Fri . . 06 Sat . . 07

No food purchased . . 01
Diary not kept . . . 02

Part 1

FOOD AND BEVERAGES (Continued)

All Other Foods

Cereals, non-dairy whipped cream, flour, sugar, coffee, teabags, macaroni, etc.

a LINE NO.	b Food Type (Describe the food purchased, such as whole milk, ground beef, apples, all purpose flour, saltines, etc.)	c Is this food – Mark (X) one: Fresh	Frozen	Bottled or Canned	Other	d Total Cost Exclude sales tax: Dollars	Cents	OFFICE USE ONLY
026		1	2	3	4	$		
027		1	2	3	4			
028		1	2	3	4			
029		1	2	3	4			
030		1	2	3	4			
031		1	2	3	4			
032		1	2	3	4			
033		1	2	3	4			
034		1	2	3	4			
035		1	2	3	4			
036		1	2	3	4			

Part 2

MEALS, SNACKS, AND BEVERAGES PURCHASED AT A RESTAURANT, CARRY-OUT, ETC.

Breakfasts, dinners, school lunches, vending machine snacks, and drinks purchased at a restaurant, lounge, etc.

a LINE NO.	b List meals, snacks, or beverages purchased away from home	c Total Cost Include tips: Dollars	Cents	d Were alcoholic beverages included in total cost? Mark (X): Yes	No	IF YES, How Much? Dollars	Cents	OFFICE USE ONLY
050		$		1	2	$		
051				1	2			
052				1	2			
053				1	2			
054				1	2			
055				1	2			
056				1	2			
057				1	2			
058				1	2			
059				1	2			

IF MORE SPACE IS NEEDED TO WRITE DOWN FOOD AND BEVERAGES OR MEALS, SNACKS, AND BEVERAGES BOUGHT AWAY FROM HOME, GO TO PAGES 22 - 24.

SECOND DAY — ENTER DAY

Part 1

FOOD AND BEVERAGES

	a LINE NO.	b Food Type (Describe the food purchased, such as whole milk, ground beef, apples, all purpose flour, saltines, etc.)	c Is this food – Mark (X) one: Fresh	Frozen	Bottled or Canned	Other	d Total Cost Exclude sales tax: Dollars	Cents	OFFICE USE ONLY
Dairy and Bakery Products Pastry, brownies, bread, milk, cream, eggs, etc.	001		1	2	3	4	$		
	002		1	2	3	4			
	003		1	2	3	4			
	004		1	2	3	4			
	005		1	2	3	4			
	006		1	2	3	4			
	007		1	2	3	4			
	008		1	2	3	4			
	009		1	2	3	4			
Meat, Fish, and Poultry Beef brisket, trout, chicken parts, etc.	010		1	2	3	4			
	011		1	2	3	4			
	012		1	2	3	4			
	013		1	2	3	4			
	014		1	2	3	4			
	015		1	2	3	4			
Fruits and Vegetables Apples, peaches, apricots, onions, tomatoes, etc.	016		1	2	3	4			
	017		1	2	3	4			
	018		1	2	3	4			
	019		1	2	3	4			
	020		1	2	3	4			
	021		1	2	3	4			
	022		1	2	3	4			
Beverages Juice, gingerale, colas, etc.	023		1	2	3	4			
	024		1	2	3	4			
	025		1	2	3	4			

SECOND DAY -- CONTINUED

Sun . . 01 Tue . . 03 Thu . . 05 Sat . . 07
Mon . . 02 Wed . . 04 Fri . . 06

No food purchased . . 01
Diary not kept . . . 02

Part 1

FOOD AND BEVERAGES (Continued)

All Other Foods

Cereals, non-dairy whipped cream, flour, sugar, coffee, teabags, macaroni, etc.

a LINE NO.	b Food Type (Describe the food purchased, such as whole milk, ground beef, apples, all purpose flour, saltines, etc.)	c Is this food – Mark (X) one: Fresh	Frozen	Bottled or Canned	Other	d Total Cost Exclude sales tax: Dollars	Cents	OFFICE USE ONLY
026		1	2	3	4	$		
027		1	2	3	4			
028		1	2	3	4			
029		1	2	3	4			
030		1	2	3	4			
031		1	2	3	4			
032		1	2	3	4			
033		1	2	3	4			
034		1	2	3	4			
035		1	2	3	4			
036		1	2	3	4			

Part 2

MEALS, SNACKS, AND BEVERAGES PURCHASED AT A RESTAURANT, CARRY-OUT, ETC.

Breakfasts, dinners, school lunches, vending machine snacks, and drinks purchased at a restaurant, lounge, etc.

a LINE NO.	b List meals, snacks, or beverages purchased away from home	c Total Cost Include tips: Dollars	Cents	d Were alcoholic beverages included in total cost? Mark (X): Yes	No	IF YES, How Much? Dollars	Cents	OFFICE USE ONLY
050		$		1	2	$		
051				1	2			
052				1	2			
053				1	2			
054				1	2			
055				1	2			
056				1	2			
057				1	2			
058				1	2			
059				1	2			

IF MORE SPACE IS NEEDED TO WRITE DOWN FOOD AND BEVERAGES OR MEALS, SNACKS, AND BEVERAGES BOUGHT AWAY FROM HOME, GO TO PAGES 22 - 24.

THIRD DAY | ENTER DAY

Part 1

FOOD AND BEVERAGES

a LINE NO.	b Food Type (Describe the food purchased, such as whole milk, ground beef, apples, all purpose flour, saltines, etc.)	c Is this food — Mark (X) one: Fresh	Frozen	Bottled or Canned	Other	d Total Cost Exclude sales tax: Dollars	Cents	OFFICE USE ONLY
	Dairy and Bakery Products — Pastry, brownies, bread, milk, cream, eggs, etc.							
001		1	2	3	4	$		
002		1	2	3	4			
003		1	2	3	4			
004		1	2	3	4			
005		1	2	3	4			
006		1	2	3	4			
007		1	2	3	4			
008		1	2	3	4			
009		1	2	3	4			
	Meat, Fish, and Poultry — Beef brisket, trout, chicken parts, etc.							
010		1	2	3	4			
011		1	2	3	4			
012		1	2	3	4			
013		1	2	3	4			
014		1	2	3	4			
015		1	2	3	4			
	Fruits and Vegetables — Apples, peaches, apricots, onions, tomatoes, etc.							
016		1	2	3	4			
017		1	2	3	4			
018		1	2	3	4			
019		1	2	3	4			
020		1	2	3	4			
021		1	2	3	4			
022		1	2	3	4			
	Beverages — Juice, gingerale, colas, etc.							
023		1	2	3	4			
024		1	2	3	4			
025		1	2	3	4			

THIRD DAY -- CONTINUED

Sun. . 01 Tue. . 03 Thu. . 05 Sat . . 07
Mon. . 02 Wed. . 04 Fri . . 06

No food purchased. . 01
Diary not kept . . . 02

Part 1

FOOD AND BEVERAGES (Continued)

All Other Foods

Cereals, non-dairy whipped cream, flour, sugar, coffee, teabags, macaroni, etc.

a LINE NO.	b Food Type *(Describe the food purchased, such as whole milk, ground beef, apples, all purpose flour, saltines, etc.*	c Is this food – *Mark (X) one* Fresh	Frozen	Bottled or Canned	Other	d Total Cost *Exclude sales tax* Dollars	Cents	OFFICE USE ONLY
026		1	2	3	4	$		
027		1	2	3	4			
028		1	2	3	4			
029		1	2	3	4			
030		1	2	3	4			
031		1	2	3	4			
032		1	2	3	4			
033		1	2	3	4			
034		1	2	3	4			
035		1	2	3	4			
036		1	2	3	4			

Part 2

MEALS, SNACKS, AND BEVERAGES PURCHASED AT A RESTAURANT, CARRY-OUT, ETC.

Breakfasts, dinners, school lunches, vending machine snacks, and drinks purchased at a restaurant, lounge, etc.

a LINE NO.	b List meals, snacks, or beverages purchased away from home	c Total Cost *Include tips* Dollars	Cents	Were alcoholic beverages included in total cost? *Mark (X)* Yes	No	d *IF YES,* How Much? Dollars	Cents	OFFICE USE ONLY
050		$		1	2	$		
051				1	2			
052				1	2			
053				1	2			
054				1	2			
055				1	2			
056				1	2			
057				1	2			
058				1	2			
059				1	2			

IF MORE SPACE IS NEEDED TO WRITE DOWN FOOD AND BEVERAGES OR MEALS, SNACKS, AND BEVERAGES BOUGHT AWAY FROM HOME, GO TO PAGES 22 - 24.

FOURTH DAY | ENTER DAY

Part 1 FOOD AND BEVERAGES	a LINE NO.	b Food Type (Describe the food purchased, such as whole milk, ground beef, apples, all purpose flour, saltines, etc.)	c Is this food — Mark (X) one: Fresh	Frozen	Bottled or Canned	Other	d Total Cost Exclude sales tax: Dollars	Cents	OFFICE USE ONLY
Dairy and Bakery Products Pastry, brownies, bread, milk, cream, eggs, etc.	001		1	2	3	4	$		
	002		1	2	3	4			
	003		1	2	3	4			
	004		1	2	3	4			
	005		1	2	3	4			
	006		1	2	3	4			
	007		1	2	3	4			
	008		1	2	3	4			
	009		1	2	3	4			
Meat, Fish, and Poultry Beef brisket, trout, chicken parts, etc.	010		1	2	3	4			
	011		1	2	3	4			
	012		1	2	3	4			
	013		1	2	3	4			
	014		1	2	3	4			
	015		1	2	3	4			
Fruits and Vegetables Apples, peaches, apricots, onions, tomatoes, etc.	016		1	2	3	4			
	017		1	2	3	4			
	018		1	2	3	4			
	019		1	2	3	4			
	020		1	2	3	4			
	021		1	2	3	4			
	022		1	2	3	4			
Beverages Juice, gingerale, colas, etc.	023		1	2	3	4			
	024		1	2	3	4			
	025		1	2	3	4			

FOURTH DAY -- CONTINUED | Sun . . 01 Tue . . 03 Thu . . 05 Sat . . 07 Mon . . 02 Wed . . 04 Fri . . 06 | No food purchased . . 01 Diary not kept . . . 02

Part 1

FOOD AND BEVERAGES (Continued)

All Other Foods

Cereals, non-dairy whipped cream, flour, sugar, coffee, teabags, macaroni, etc.

a LINE NO.	b Food Type *(Describe the food purchased, such as whole milk, ground beef, apples, all purpose flour, saltines, etc.*	c Is this food — *Mark (X) one* Fresh	Frozen	Bottled or Canned	Other	d Total Cost *Exclude sales tax* Dollars	Cents	OFFICE USE ONLY
026		1	2	3	4	$		
027		1	2	3	4			
028		1	2	3	4			
029		1	2	3	4			
030		1	2	3	4			
031		1	2	3	4			
032		1	2	3	4			
033		1	2	3	4			
034		1	2	3	4			
035		1	2	3	4			
036		1	2	3	4			

Part 2

MEALS, SNACKS, AND BEVERAGES PURCHASED AT A RESTAURANT, CARRY-OUT, ETC.

Breakfasts, dinners, school lunches, vending machine snacks, and drinks purchased at a restaurant, lounge, etc.

a LINE NO.	b List meals, snacks, or beverages purchased away from home	c Total Cost *Include tips* Dollars	Cents	d Were alcoholic beverages included in total cost? *Mark (X)* Yes	No	*IF YES,* How Much? Dollars	Cents	OFFICE USE ONLY
050		$		1	2	$		
051				1	2			
052				1	2			
053				1	2			
054				1	2			
055				1	2			
056				1	2			
057				1	2			
058				1	2			
059				1	2			

IF MORE SPACE IS NEEDED TO WRITE DOWN FOOD AND BEVERAGES OR MEALS, SNACKS, AND BEVERAGES BOUGHT AWAY FROM HOME, GO TO PAGES 22 - 24.

FIFTH DAY — ENTER DAY

Part 1 FOOD AND BEVERAGES	a LINE NO.	b Food Type (Describe the food purchased, such as whole milk, ground beef, apples, all purpose flour, saltines, etc.)	c Is this food – Mark (X) one: Fresh	Frozen	Bottled or Canned	Other	d Total Cost Exclude sales tax: Dollars	Cents	OFFICE USE ONLY
Dairy and Bakery Products Pastry, brownies, bread, milk, cream, eggs, etc.	001		1	2	3	4	$		
	002		1	2	3	4			
	003		1	2	3	4			
	004		1	2	3	4			
	005		1	2	3	4			
	006		1	2	3	4			
	007		1	2	3	4			
	008		1	2	3	4			
	009		1	2	3	4			
Meat, Fish, and Poultry Beef brisket, trout, chicken parts, etc.	010		1	2	3	4			
	011		1	2	3	4			
	012		1	2	3	4			
	013		1	2	3	4			
	014		1	2	3	4			
	015		1	2	3	4			
Fruits and Vegetables Apples, peaches, apricots, onions, tomatoes, etc.	016		1	2	3	4			
	017		1	2	3	4			
	018		1	2	3	4			
	019		1	2	3	4			
	020		1	2	3	4			
	021		1	2	3	4			
	022		1	2	3	4			
Beverages Juice, gingerale, colas, etc.	023		1	2	3	4			
	024		1	2	3	4			
	025		1	2	3	4			

FIFTH DAY -- CONTINUED

Sun . . 01 Tue . . 03 Thu . . 05 Sat . . 07
Mon . . 02 Wed . . 04 Fri . . 06

No food purchased . . 01
Diary not kept . . . 02

Part 1

FOOD AND BEVERAGES (Continued)

All Other Foods

Cereals, non-dairy whipped cream, flour, sugar, coffee, teabags, macaroni, etc.

a LINE NO.	b Food Type (Describe the food purchased, such as whole milk, ground beef, apples, all purpose flour, saltines, etc.)	c Is this food — Mark (X) one: Fresh	Frozen	Bottled or Canned	Other	d Total Cost Exclude sales tax: Dollars	Cents	OFFICE USE ONLY
026		1	2	3	4	$		
027		1	2	3	4			
028		1	2	3	4			
029		1	2	3	4			
030		1	2	3	4			
031		1	2	3	4			
032		1	2	3	4			
033		1	2	3	4			
034		1	2	3	4			
035		1	2	3	4			
036		1	2	3	4			

Part 2

MEALS, SNACKS, AND BEVERAGES PURCHASED AT A RESTAURANT, CARRY-OUT, ETC.

Breakfasts, dinners, school lunches, vending machine snacks, and drinks purchased at a restaurant, lounge, etc.

a LINE NO.	b List meals, snacks, or beverages purchased away from home	c Total Cost Include tips: Dollars	Cents	Were alcoholic beverages included in total cost? Mark (X): Yes	No	d IF YES, How Much?: Dollars	Cents	OFFICE USE ONLY
050		$		1	2	$		
051				1	2			
052				1	2			
053				1	2			
054				1	2			
055				1	2			
056				1	2			
057				1	2			
058				1	2			
059				1	2			

IF MORE SPACE IS NEEDED TO WRITE DOWN FOOD AND BEVERAGES OR MEALS, SNACKS, AND BEVERAGES BOUGHT AWAY FROM HOME, GO TO PAGES 22 - 24.

SIXTH DAY — ENTER DAY

Part 1

FOOD AND BEVERAGES

a	b	c				d		OFFICE USE ONLY
LINE NO.	Food Type *(Describe the food purchased, such as whole milk, ground beef, apples, all purpose flour, saltines, etc.)*	Is this food – *Mark (X) one*				Total Cost *Exclude sales tax*		
		Fresh	Frozen	Bottled or Canned	Other	Dollars	Cents	
Dairy and Bakery Products *Pastry, brownies, bread, milk, cream, eggs, etc.*								
001		1	2	3	4	$		
002		1	2	3	4			
003		1	2	3	4			
004		1	2	3	4			
005		1	2	3	4			
006		1	2	3	4			
007		1	2	3	4			
008		1	2	3	4			
009		1	2	3	4			
Meat, Fish, and Poultry *Beef brisket, trout, chicken parts, etc.*								
010		1	2	3	4			
011		1	2	3	4			
012		1	2	3	4			
013		1	2	3	4			
014		1	2	3	4			
015		1	2	3	4			
Fruits and Vegetables *Apples, peaches, apricots, onions, tomatoes, etc.*								
016		1	2	3	4			
017		1	2	3	4			
018		1	2	3	4			
019		1	2	3	4			
020		1	2	3	4			
021		1	2	3	4			
022		1	2	3	4			
Beverages *Juice, gingerale, colas, etc.*								
023		1	2	3	4			
024		1	2	3	4			
025		1	2	3	4			

SIXTH DAY -- CONTINUED | Sun . . 01 Mon . . 02 Tue . . 03 Wed . . 04 Thu . . 05 Fri . . 06 Sat . . 07 | No food purchased . . 01 Diary not kept . . . 02

Part 1

FOOD AND BEVERAGES (Continued)

All Other Foods

Cereals, non-dairy whipped cream, flour, sugar, coffee, teabags, macaroni, etc.

a LINE NO.	b Food Type (Describe the food purchased, such as whole milk, ground beef, apples, all purpose flour, saltines, etc.)	c Is this food – Mark (X) one: Fresh	Frozen	Bottled or Canned	Other	d Total Cost Exclude sales tax: Dollars	Cents	OFFICE USE ONLY
026		1	2	3	4	$		
027		1	2	3	4			
028		1	2	3	4			
029		1	2	3	4			
030		1	2	3	4			
031		1	2	3	4			
032		1	2	3	4			
033		1	2	3	4			
034		1	2	3	4			
035		1	2	3	4			
036		1	2	3	4			

Part 2

MEALS, SNACKS, AND BEVERAGES PURCHASED AT A RESTAURANT, CARRY-OUT, ETC.

Breakfasts, dinners, school lunches, vending machine snacks, and drinks purchased at a restaurant, lounge, etc.

a LINE NO.	b List meals, snacks, or beverages purchased away from home	c Total Cost Include tips: Dollars	Cents	d Were alcoholic beverages included in total cost? Mark (X): Yes	No	IF YES, How Much? Dollars	Cents	OFFICE USE ONLY
050		$		1	2	$		
051				1	2			
052				1	2			
053				1	2			
054				1	2			
055				1	2			
056				1	2			
057				1	2			
058				1	2			
059				1	2			

IF MORE SPACE IS NEEDED TO WRITE DOWN FOOD AND BEVERAGES OR MEALS, SNACKS, AND BEVERAGES BOUGHT AWAY FROM HOME, GO TO PAGES 22 - 24.

SEVENTH DAY | ENTER DAY

Part 1

FOOD AND BEVERAGES

	a LINE NO.	b Food Type (Describe the food purchased, such as whole milk, ground beef, apples, all purpose flour, saltines, etc.)	c Is this food – Mark (X) one: Fresh	Frozen	Bottled or Canned	Other	d Total Cost Exclude sales tax: Dollars	Cents	OFFICE USE ONLY
Dairy and Bakery Products Pastry, brownies, bread, milk, cream, eggs, etc.	001		1	2	3	4	$		
	002		1	2	3	4			
	003		1	2	3	4			
	004		1	2	3	4			
	005		1	2	3	4			
	006		1	2	3	4			
	007		1	2	3	4			
	008		1	2	3	4			
	009		1	2	3	4			
Meat, Fish, and Poultry Beef brisket, trout, chicken parts, etc.	010		1	2	3	4			
	011		1	2	3	4			
	012		1	2	3	4			
	013		1	2	3	4			
	014		1	2	3	4			
	015		1	2	3	4			
Fruits and Vegetables Apples, peaches, apricots, onions, tomatoes, etc.	016		1	2	3	4			
	017		1	2	3	4			
	018		1	2	3	4			
	019		1	2	3	4			
	020		1	2	3	4			
	021		1	2	3	4			
	022		1	2	3	4			
Beverages Juice, gingerale, colas, etc.	023		1	2	3	4			
	024		1	2	3	4			
	025		1	2	3	4			

SEVENTH DAY -- CONTINUED

Sun . . 01 Tue . . 03 Thu . . 05 Sat . . 07
Mon . . 02 Wed . . 04 Fri . . 06

No food purchased . . 01
Diary not kept . . . 02

Part 1 — FOOD AND BEVERAGES (Continued)

All Other Foods

Cereals, non-dairy whipped cream, flour, sugar, coffee, teabags, macaroni, etc.

a LINE NO.	b Food Type (Describe the food purchased, such as whole milk, ground beef, apples, all purpose flour, saltines, etc.)	c Is this food — Mark (X) one: Fresh	Frozen	Bottled or Canned	Other	d Total Cost Exclude sales tax: Dollars	Cents	OFFICE USE ONLY
026		1	2	3	4	$		
027		1	2	3	4			
028		1	2	3	4			
029		1	2	3	4			
030		1	2	3	4			
031		1	2	3	4			
032		1	2	3	4			
033		1	2	3	4			
034		1	2	3	4			
035		1	2	3	4			
036		1	2	3	4			

Part 2 — MEALS, SNACKS, AND BEVERAGES PURCHASED AT A RESTAURANT, CARRY-OUT, ETC.

Breakfasts, dinners, school lunches, vending machine snacks, and drinks purchased at a restaurant, lounge, etc.

a LINE NO.	b List meals, snacks, or beverages purchased away from home	c Total Cost Include tips: Dollars	Cents	d Were alcoholic beverages included in total cost? Mark (X): Yes	No	IF YES, How Much? Dollars	Cents	OFFICE USE ONLY
050		$		1	2	$		
051				1	2			
052				1	2			
053				1	2			
054				1	2			
055				1	2			
056				1	2			
057				1	2			
058				1	2			
059				1	2			

IF MORE SPACE IS NEEDED TO WRITE DOWN FOOD AND BEVERAGES OR MEALS, SNACKS, AND BEVERAGES BOUGHT AWAY FROM HOME, GO TO PAGES 22 - 24.

ADDITIONAL PAGE FOR PART 1 - FOOD AND BEVERAGES									
a	b		c				d		
LINE NO.	Enter Day	Food Type *(Describe the food purchased, such as whole milk, ground beef, apples, all purpose flour, saltines, etc.)*	Is this food – *Mark (X) one* Fresh	Frozen	Bottled or Canned	Other	Total Cost *Exclude sales tax* Dollars	Cents	OFFICE USE ONLY (1)	(2)
001			1	2	3	4	$			
002			1	2	3	4	$			
003			1	2	3	4	$			
004			1	2	3	4	$			
005			1	2	3	4	$			
006			1	2	3	4	$			
007			1	2	3	4	$			
008			1	2	3	4	$			
009			1	2	3	4	$			
010			1	2	3	4	$			
011			1	2	3	4	$			
012			1	2	3	4	$			
013			1	2	3	4	$			
014			1	2	3	4	$			
015			1	2	3	4	$			
016			1	2	3	4	$			
017			1	2	3	4	$			
018			1	2	3	4	$			
019			1	2	3	4	$			
020			1	2	3	4	$			
021			1	2	3	4	$			
022			1	2	3	4	$			
023			1	2	3	4	$			
024			1	2	3	4	$			
025			1	2	3	4	$			

ADDITIONAL PAGE FOR PART 1 - FOOD AND BEVERAGES (Continued)											
a	b		c				d		OFFICE USE ONLY	
LINE NO.	Enter Day	Food Type *(Describe the food purchased, such as whole milk, ground beef, apples, all purpose flour, saltines, etc.)*	Is this food – *Mark (X) one*				Total Cost *Exclude sales tax.*			
			Fresh	Frozen	Bottled or Canned	Other	Dollars	Cents	(1)	(2)
026			1	2	3	4	$			
027			1	2	3	4	$			
028			1	2	3	4	$			
029			1	2	3	4	$			
030			1	2	3	4	$			
031			1	2	3	4	$			
032			1	2	3	4	$			
033			1	2	3	4	$			
034			1	2	3	4	$			
035			1	2	3	4	$			
036			1	2	3	4	$			
037			1	2	3	4	$			
038			1	2	3	4	$			
039			1	2	3	4	$			
040			1	2	3	4	$			
041			1	2	3	4	$			
042			1	2	3	4	$			
043			1	2	3	4	$			
044			1	2	3	4	$			
045			1	2	3	4	$			
046			1	2	3	4	$			
047			1	2	3	4	$			
048			1	2	3	4	$			
049			1	2	3	4	$			

ADDITIONAL PAGE FOR PART 2 - MEALS, SNACKS, AND BEVERAGES PURCHASED AT A RESTAURANT, CARRY-OUT, ETC.

a	a	b	c		d				
LINE NO.	Enter Day	List meals, snacks, or beverages purchased away from home	Total Cost *Include tips*		Were alconolic beverages included in total cost? *Mark (X)*		*IF YES,* How Much?		OFFICE USE ONLY
			Dollars	Cents	Yes	No	Dollars	Cents	(1) (2)
050			$		1	2	$		
051			$		1	2	$		
052			$		1	2	$		
053			$		1	2	$		
054			$		1	2	$		
055			$		1	2	$		
056			$		1	2	$		
057			$		1	2	$		
058			$		1	2	$		
059			$		1	2	$		
060			$		1	2	$		
061			$		1	2	$		
062			$		1	2	$		
063			$		1	2	$		
064			$		1	2	$		
065			$		1	2	$		
066			$		1	2	$		
067			$		1	2	$		
068			$		1	2	$		
069			$		1	2	$		
070			$		1	2	$		
071			$		1	2	$		
072			$		1	2	$		

DAILY REMINDER LIST

Please review the types of food and beverages listed below with other members of your family unit at the end of each day. If you have not written down a food or beverage cost, please do so on the page for that day.

DON'T FORGET TO RECORD COSTS FOR...

- Milk, cheese, eggs, cereal (hot or cold), etc.
- Flour, sugar, salt, shortening, cake mixes, etc.
- Fruit or vegetable juice, dried beans or peas, peanut butter, etc.
- Canned soup, tomato paste, chili mix, salad dressing, etc.
- Food and beverages purchased at a restaurant or carry-out (including school lunches and vending machines).
- Snack foods (potato chips, pretzels, cookies, chocolate bars, etc.).
- Foods purchased with food stamps, WIC vouchers, or benefits from other food programs.

OMB No. 0584-0306
Expires 12/31/83

CHILD'S INTERVIEW PACKAGE

A Study of
Health and Nutrition of Mothers and Their Children

Sponsored by

Food and Nutrition Service
U.S. Department of Agriculture

Conducted by

New York State Research Foundation
and
Research Triangle Institute

ID LABEL

CHILD'S NAME (FIRST, MIDDLE, LAST)			DATE OF BIRTH Month Day Year	AGE
MOTHER'S NAME (FIRST, MIDDLE, LAST)			MOTHER'S ID NUMBER	
PSU #	CLINIC #	OPERATIVE NAME		ID NUMBER

CHILD INTERVIEW PACKAGE INSTRUCTIONS

1. Is this child the selected 0 through 4-year-old sample child?

Yes . . . . . 01 →
- ☐ Consent Form
- ☐ Dietary Interview
- ☐ Child Health Questionnaire
- ☐ Child Measurement Form

No. . . . . 02 → (Q. 3.)

2. Is this selected sample child 4 years old?

Yes, 4 years old . . . . 01 →
- ☐ Picture Vocabulary Test
- ☐ Numerical Memory Test
- ☐ Behavior Inventory
- ☐ Interviewer Rating of Maternal Behavior

No, less than 4 years old . . . . 02 → STOP!

3. Is this child 4 or 5 years old, but <u>not</u> the selected sample child?

Yes, 4 or 5 years old . 01 →
- ☐ Consent Form
- ☐ Child Health Questionnaire
- ☐ Child Measurement Form
- ☐ Picture Vocabulary Test
- ☐ Numerical Memory Test
- ☐ Behavior Inventory
- ☐ Interviewer Rating of Maternal Behavior

No, less than 4 years old . . . . 02 → STOP!

Start Time _____ am
pm

CHILD'S DIETARY INTERVIEW

(24-HOUR RECALL)

DATE COMPLETED

☐☐	☐☐	☐☐
Month	Day	Year

DAY OF WEEK

Monday 01
Tuesday 02
Wednesday. . . . 03
Thursday 04
Friday 05
Saturday 06
Sunday 07

RELATIONSHIP OF RESPONDENT TO CHILD

Mother 01
Father 02
Brother or
Sister 03
Grandparent. . . 04
Other (SPECIFY). 05

_____

_____

MEASUREMENT CONVERSIONS

3 teaspoons = 1 tablespoon
2 tablespoons = 1 fluid ounce
4 tablespoons = ¼ cup
5 1/3 tablespoons = 1/3 cup
16 tablespoons = 1 cup = 8 ounces = ½ pint
2 cups = 1 pint
2 pints = 1 quart

NOTES: _____

	WORKSPACE	TOTAL AMOUNT	CODE
Whole Milk		oz	001
Skim Milk		oz	002
1% Milk		oz	003
2% Milk		oz	004
Buttermilk		oz	005
Chocolate Milk		oz	006
Hot Chocolate/Cocoa		oz	007
Evaporated Milk		oz	008
Nonfat Dry Milk, Prepared		oz	009
Ice Cream Flavors, Not Chocolate		C	010
Ice Cream, Chocolate		C	011
Sugar Cone		ea	012
Pudding, Chocolate Mix		C	013
Pudding, Vanilla Mix		C	014
Yogurt, Plain, Low Fat		C	015
Yogurt, Fruit, Low Fat		C	016
American Processed Cheese			017
American Cheese Food			018
American Cheese Food Spread		T	019
Cheddar/Brick Cheese			020
Colby Cheese			021
Cottage Cheese		C	022
Monterey Jack Cheese			023
Mozzarella Cheese			024
Muenster Cheese			025
Parmesan Cheese, Grated		t	026
Provolone Cheese			027
Swiss Cheese			028
Other:			

NOTES: _____

MEAT
POULTRY
EGGS

	WORKSPACE	TOTAL AMOUNT			CODE
Beef/Veal/Lamb:					
Beef, Ground/Hamburger					029
Corned Beef/Pastrami					030
Lamb					031
Meatloaf/Meatballs					032
Pot Roast					033
Ribs, Braised					034
Roast Beef					035
Salisbury Steak					036
Steak, Broiled, Fat Trimmed					037
Steak, Broiled, Fat Not Trimmed					038
Steak, Fried					039
Veal, Chop or Roast					040
Veal Cutlet, Fried					041
Pork:					
Bacon				sl	042
Chops/Steak					043
Ham, Cured					044
Ham Hocks				ea	045
Ham Salad				T	046
Pork, Neckbones				ea	047
Pork, Pigs Feet, Pickled				ea	048
Pork Roast					049
Spareribs, Braised					050
Sausages and Luncheon Meats:					
Beef, Pressed					051
Bologna, All Kinds					052
Deviled Ham/Spam				T	053
Frankfurter, All Kinds				ea	054
Ham, Boiled, Lunchmeat					055
Liverwurst					056
Luncheon Loaf w/Olive, Pickle, Pimento					057
Polish/Italian Sausage					058
Pork Sausage					059
Salami/Pepperoni/Summer Sausage					060
Poultry and Eggs:					
Chicken Breast, Fried				ea	061
Chicken Drumstick, Fried				ea	062
Chicken Thigh, Fried				ea	063
Chicken Wing, Fried				ea	064
Chicken/Turkey, Roast w/ Skin					065
Chicken/Turkey, Roast w/o Skin					066
Eggs, Scrambled				ea	067
Eggs, Hard or Soft Cooked, Poached or Fried				ea	068
Egg Salad				T	069
Other:					

	WORKSPACE	TOTAL AMOUNT	CODE
Fish and Seafood:			
Cod/Flounder, Baked		.	070
Cod, Salt			071
Fish/Catfish, Fried			072
Fish Sticks			073
Haddock, Broiled			074
Shrimp, Canned		C	075
Shrimp, Fried		C	076
Tuna, Canned in Oil, Drained Solids		C	077
Tuna, Canned in Water		C	078
Tuna Salad		T	079
Meat Alternates:			
Beans, Black, Cooked		C	080
Beans, Fried/Refried, Cooked		C	081
Beans, Garbanzo/Chick Peas, Cooked		C	082
Beans, Lima, Mature, Cooked		C	083
Beans, Pinto/Calico, Cooked		C	084
Beans, Red/Kidney, Cooked		C	085
Beans, White/Navy, Cooked		C	086
Lentils, Cooked		C	087
Peanut Butter		T	088
Peanuts		T	089
Peas, Blackeyed/Cowpeas, Cooked		C	090
Peas, Split, Cooked		C	091
Soups (Ready-To-Serve):			
Bean		C	092
Broth/Consommé, Beef, Canned		C	093
Broth/Consommé, Chicken, Canned		C	094
Chicken Noodle		C	095
Chicken Rice		C	096
Codfish Soup w/Noodles, Puerto Rican Style		C	097
Cream of Chicken		C	098
Cream of Mushroom		C	099
Cream of Potato		C	100
Cream of Tomato		C	101
Fish Chowder		C	102
Tomato		C	103
Vegetable Beef		C	104
Vegetable Noodle		C	105
Vegetarian Vegetable		C	106
Other:			

CASSEROLES
HONEY, SUGAR, SYRUP
CONDIMENTS

	WORKSPACE	TOTAL AMOUNT	CODE
Casseroles and Combinations (Ready-To-Serve):			
Beef and Vegetable Stew		C	107
Beef, Ground w/Vegetables Casserole		C	108
Beef, Pot Pie, 4"		ea	109
Burritos (Tortilla, Meat, Refried Beans)		ea	110
Chicken and Dumplings		C	111
Chicken/Turkey Pot Pie, 4"		ea	112
Chili Con Carne w/Beans		C	113
Chili Con Carne w/o Beans		C	114
Goulash, Beef w/Noodles		C	115
Lasagna			116
Macaroni and Cheese		C	117
Macaroni w/Chicken		C	118
Macaroni w/Tuna		C	119
Pizza, Cheese			120
Pizza, Meat & Cheese			121
Pork and Beans		C	122
Ravioli, w/Meat		C	123
Spaghetti, Meat & Tomato Sauce		C	124
Spaghetti, Cheese & Tomato Sauce			125
Honey, Sugar, Syrup:			
Honey		t	126
Jams/Jellies		t	127
Sugar		t	128
Molasses		t	129
Chocolate Syrup, Thin Type		t	130
Chocolate Topping, Thick Fudge Type		t	131
Chocolate Powder		t	132
Pancake Syrup		t	133
Condiments:			
B-B-Q Sauce		t	134
Catsup		t	135
Mustard		t	136
Pickle, Dill, 3 3/4" Long x 1 1/4" Thick		ea	137
Pickle Relish		t	138
Pickle, Sweet, 2 1/2" Long x 3/4 " Thick		ea	139
Tomato Chili Sauce		t	140
Other:			

	WORKSPACE	TOTAL AMOUNT	CODE
Apple, Baked w/Sugar		ea	141
Apple Juice		oz	142
Apple, Raw		ea	143
Apple Sauce		C	144
Apricots, Canned, Heavy Syrup		C	145
Avocado, Raw		ea	146
Banana, Raw		ea	147
Cantelope, Raw		C	148
Cranberry Juice		oz	149
Cranberry Sauce		T	150
Fruit Cocktail, Canned, Heavy Syrup		C	151
Grapefruit Juice		oz	152
Grapefruit, Raw		ea	153
Grape Juice		oz	154
Grapes, Raw		C	155
Lemon Juice		t	156
Lemon, Raw		sl	157
Orange Juice		oz	158
Orange, Raw		ea	159
Orange-Grapefruit Juice		oz	160
Peaches, Canned, Heavy Syrup		C	161
Peach, Raw		ea	162
Pineapple, Canned, Heavy Syrup		C	163
Pineapple Juice		oz	164
Plum, Raw		ea	165
Prune, Dried		ea	166
Raisins		T	167
Strawberries, Raw		C	168
Tangelos/Tangerines, Raw		ea	169
Watermelon, Raw		C	170
Other:			

NOTES: _____

VEGETABLES

	WORKSPACE	TOTAL AMOUNT	CODE
Asparagus, Cooked		C	171
Beans, Baby Limas, Cooked		C	172
Beans, Green or Yellow Snap		C	173
Bean Sprouts, Raw		C	174
Beets, Cooked		C	175
Broccoli, Cooked		C	176
Brussel Sprouts, Cooked		C	177
Cabbage, Cooked		C	178
Carrots, Cooked		C	179
Carrots, Raw		ea	180
Cauliflower, Cooked		C	181
Celery Stalk, Raw		ea	182
Coleslaw, All Types		C	183
Collard Greens, Cooked		C	184
Corn on Cob, Cooked, Ear		ea	185
Corn, Cream Style, Cooked		C	186
Corn, White Kernel, Cooked		C	187
Cucumbers, Raw		ea	188
Lettuce, Head & Leaf		C	189
Mixed Vegetables, Cooked		C	190
Mushrooms, Cooked		C	191
Mustard/Turnip Greens, Cooked		C	192
Okra, Cooked		C	193
Onions, Green/Scallions, Raw		ea	194
Onions, Mature, Raw		C	195
Peas, Green, Cooked		C	196
Peas and Carrots, Cooked		C	197
Peppers, Sweet Green, Raw		C	198
Potatoes, Au Gratin		C	199
Potatoes, Baked in Skin		ea	200
Potatoes, Boiled		ea	201
Potatoes, Creamed/Scalloped		C	202
Potatoes, Hash Browns/Home Fries		C	203
Potatoes, French Fried		C	204
Potatoes, Mashed		C	205
Potato Salad		C	206
Radishes, Raw		ea	207
Salad, Tossed (Lettuce & Tomato)		C	208
Sauerkraut		C	209
Spinach, Cooked		C	210
Squash, Summer/Zucchini, Cooked		C	211
Squash, Winter		C	212
Sweet Potatoes, Baked		ea	213
Sweet Potatoes, Candied		C	214
Tomatoes, Canned		C	215
Tomatoes, Raw		ea	216
Tomato Sauce		C	217
Turnips, Cooked		C	218
Other:			

	WORKSPACE	TOTAL AMOUNT	CODE
Bread Stuffing/Dressing		C	219
Breadcrumbs, Dry (Commercial)		T	220
Breads:			
Bagels		ea	221
Biscuits		ea	222
Cornbread			223
English Muffin		ea	224
French Bread (2½" wide)		sl	225
Hamburger/Frankfurter Bun		ea	226
Muffin, Blueberry		ea	227
Rolls:			
Cinnamon Bun		ea	228
Dinner/Soft, Brown'Serve		ea	229
Hard/Kaiser		ea	230
Hoagie/Submarine (11½" x 3" x 2½")		ea	231
Rye Bread		sl	232
White Bread		sl	233
Wheat Bread		sl	234
Corngrits/Hominy Grits		C	235
Cornbread Stuffing/Dressing		C	236
Crackers:			
Butter		ea	237
Graham		ea	238
Soda/Saltines, 2" Square		ea	239
Wheat		ea	240
Croutons, Plain, Toasted		T	241
French Toast, Plain, Homemade		sl	242
Macaroni/Noodles, Cooked		C	243
Pancakes, Waffles			244
Rice, Brown, Cooked		C	245
Rice, Fried, Cooked		C	246
Rice, White, Cooked		C	247
Rice, Spanish, Cooked		C	248
Spaghetti, Plain, Cooked		C	249
Spoonbread		C	250
Tortilla, Corn		ea	251
Tortilla, Wheat		ea	252
Other:			

NOTES: _____

_____

_____

CEREALS
BEVERAGES

	WORKSPACE	TOTAL AMOUNT	CODE
Cereals:			
All Bran/Bran Buds		C	253
Body Buddies		C	254
Bran Flakes, 40% Kellogs		C	255
Cap'n Crunch		C	256
Cheerios		C	257
Corn Flakes, Not Country		C	258
Corn, Puffed (Kix)		C	259
Country Corn Flakes/Corn Total		C	260
Cream of Wheat, Regular		C	261
Cream of Wheat, Mix and Eat		C	262
Cream of Wheat, Mix and Eat, Flavored		C	263
Fruit Loops/Trix		C	264
Granola-type Cereals		C	265
Kaboom		C	266
King Vitamin		C	267
Malt-O-Meal, Chocolate & Plain		C	268
Maypo		C	269
Most		C	270
Oat Flakes, Fortified		C	271
Oatmeal		C	272
Product 19		C	273
Raisin Bran		C	274
Rice Krispies/Rice, Frosted/Sugar Corn Pops		C	275
Rice, Puffed		C	276
Sugar Frosted Flakes/Sugar Smacks		C	277
Total		C	278
Wheat, Shredded		C	279
Wheaties		C	280
Alcoholic Beverages:			
Beer		oz	281
Beer, Lite		oz	282
Dessert Wine/Sherry/Vermouth		oz	283
Wine, Table		oz	284
Whiskey/Spirits		oz	285
Nonalcoholic Beverages:			
Chocolate/Malted Milk Drink		oz	286
Coffee		oz	287
Hawaiian Punch (w/Vitamin C)		oz	288
Hi-C Fruit Drink (w/Vitamin C)		oz	289
Koolaid (w/Vitamin C)		oz	290
Lemonade		oz	291
Orange Drink/Pineapple Orange Drink		oz	292
Soda, Diet		oz	293
Soda, Regular		oz	294
Tea		oz	295
Tea, Premade w/Lemon & Sugar		oz	296
Other:			

	WORKSPACE	TOTAL AMOUNT			CODE
Cakes:					
Brownies					297
Chocolate/Devil's Food Cake w/Icing					298
Coffee Cake					299
Cup Cake w/Icing, Chocolate, 2 3/4" diameter				ea	300
Cup Cake w/Icing, Not Chocolate, 2 3/4" diameter				ea	301
Doughnuts, Plain (Cake), 3 1/2" x 1"				ea	302
Doughnuts, Glazed and Chocolate, 3 1/2" x 1"				ea	303
Pound Cake, Plain					304
Cookies:					
Animal Crackers				ea	305
Assorted Cookies					306
Butterscotch Chips					307
Chocolate Chip					308
Oatmeal/Raisin					309
Peanut					310
Sandwich Type					311
Sugar/Butter					312
Vanilla Wafers					313
Pies:					
Apple					314
Cherry					315
Chocolate					316
Lemon Meringue					317
Peach					318
Pumpkin/Squash					319
Candy:					
Caramels, Plain or Chocolate				ea	320
Chocolate, Milk, Plain					321
Fudge					322
Gum, Chewing				ea	323
Gumdrops				ea	324
Hard Candy				ea	325
Marshmallows				ea	326
Other Desserts:					
Jello, Plain				C	327
Jello, w/Fruit				C	328
Peach Cobbler				C	329
Popsicle				ea	330
Other:					

FATS AND OILS
SNACK CHIPS

	WORKSPACE	TOTAL AMOUNT	CODE
Fats and Oils:			
Butter		t	331
Cream Cheese		T	332
Cream, Half and Half		t	333
Cream, Heavy		t	334
Cream, Sour		t	335
Cream Substitute, Dry		t	336
Cream Substitute, Liquid		t	337
Cream, Whipped Topping, Non-Dairy Frozen		T	338
Gravy, Brown		T	339
Gravy, Milk		T	340
Lard		T	341
Mayonnaise		t	342
Margarine, Regular		t	343
Margarine, Whipped		t	344
Margarine, Diet		t	345
Oils, Salad & Cooking		T	346
Salad Dressings:			
Blue/Roquefort Cheese		T	347
French, Regular		T	348
French, Lo-Cal		T	349
Italian, Regular		T	350
Italian, Lo-Cal		T	351
Mayonnaise Type		T	352
Cream Type		T	353
Thousand Island		T	354
Shortening, Vegetable		t	355
White Sauce		t	356
Snack Chips:			
Corn Chips/Corn Curls		C	357
Popcorn		C	358
Potato Chips		C	359
Pretzels, Hard Stick		C	360
Other:			

NOTES: _____

_____

_____

_____

_____

	WORKSPACE	TOTAL AMOUNT	CODE
Formulas:			
Breast Milk, Human		oz	361
Enfamil, w/Iron		oz	362
Isomil		oz	363
I-Sovalac		oz	364
Lofenalac		oz	365
Meat Base Formula		oz	366
Neo-Mull-Soy		oz	367
Nursoy		oz	368
Nutramigen, Diluted		oz	369
Portagen		oz	370
Pregestimil		oz	371
Prosobee		oz	372
Similac, w/Iron		oz	373
Similac, Advance		oz	374
SMA		oz	375
Soyalac		oz	376
Enfamil, Reg.		oz	377
Similac, Reg.		oz	378
Cereals & Teething Biscuits:			
Hi-Protein, Dry		T	379
Mixed, Dry		T	380
Mixed w/Fruit		oz	381
Oatmeal, Dry		T	382
Rice, Dry		T	383
Teething Biscuits		ea	384
Fruits & Juices:			
Applesauce		oz	385
Apricots		oz	386
Bananas		oz	387
Peaches		oz	388
Pears		oz	389
Plums		oz	390
Prunes		oz	391
Juices		oz	392
Other:			

NOTES: _____

INFANT FORMULAS
AND STRAINED FOODS

	WORKSPACE	TOTAL AMOUNT	CODE
Desserts:			
Dutch Apple		oz	393
Fruit Dessert		oz	394
Hawaiian Delight		oz	395
Peach Cobbler		oz	396
Vegetables:			
Beets		oz	397
Carrots		oz	398
Green Beans		oz	399
Mixed Vegetables		oz	400
Peas		oz	401
Spinach		oz	402
Squash		oz	403
Sweet Potatoes		oz	404
Meats:			
Beef		oz	405
Chicken		oz	406
Egg Yolks		oz	407
Lamb		oz	408
Pork		oz	409
Veal		oz	410
Dinners:			
Beef & Noodles		oz	411
Chicken & Noodles		oz	412
Macaroni & Cheese		oz	413
Maraconi, Tomato & Meat		oz	414
Split Pea, Vegetable/Ham		oz	415
Turkey & Rice		oz	416
Vegetables & Beef		oz	417
Vegetables & Chicken		oz	418
Vegetables & Ham		oz	419
Vegetables & Lamb		oz	420
Vegetables & Liver		oz	421
Vegetables & Turkey		oz	422
Other:			

NOTES: _____

1. Is what (CHILD) ate yesterday the way [he/she] usually eats?

Yes . . . . . 01 (Q. 2.)
No. 02

A. Why was what (CHILD) ate yesterday different?

Illness. 01
No money 02
Sunday or holiday. 03
Other (SPECIFY). 04

_____

_____

2. Is (CHILD) on a special diet?

Yes 01
No. . . . . 02 (Q. 3.)

A. Why is [he/she] on this diet?

(CIRCLE ALL THAT APPLY.)

Lose weight. 01
Gain weight. 02
Diabetes 03
Celiac disease--gluten intolerance. 04
Allergies. 05
Other (SPECIFY). 06

_____

3. Is (CHILD) taking any vitamins or minerals?

Yes 01
No. . . . . 02 (Q. 4.)

A. What brand and type of vitamin or mineral supplements does (CHILD) take? ENTER BRAND NAME AND DESCRIPTION IN TABLE. SHOW VITAMIN/MINERAL BOOKLET, IF NECESSARY, TO DETERMINE BRAND.

B. How often does [he/she] take (NAME/DESCRIPTION)? ENTER TIMES IN TABLE.

C. (ASK IF NECESSARY:) Is that per day or some other interval? ENTER INTERVAL IN TABLE.

D. Was this prescribed or recommended by a medical person? CODE "YES" OR "NO" IN TABLE

	A	B	C	D
	BRAND NAME AND DESCRIPTION	TIMES	INTERVAL	PRESCRIBED OR RECOMMENDED?
(1)				Yes . . . 01 No. . . . 02
(2)				Yes . . . 01 No. . . . 02
(3)				Yes . . . 01 No. . . . 02
(4)				Yes . . . 01 No. . . . 02

4. Were you advised to give (CHILD) any vitamin or mineral supplements that you do not give [him/her]?

Yes 01
No. 02
Don't know/remember . . . . DK

5. Did (CHILD) have any meals or snacks in a daycare or other preschool program yesterday?

Yes 01
No. . . . . 02 } (CHECKPOINT A.)
Don't know. . . . . DK }

A. Was this breakfast, lunch, or a snack?

(CIRCLE ALL THAT APPLY.)
Breakfast. 01
Lunch. 02
Snack. 03

CHECKPOINT A

WHERE WAS THIS CHILD'S DIETARY INTERVIEW COMPLETED?

☐ CLINIC → RECORD END TIME.

☐ HOME → CHECK ONE BOX BELOW.

☐ CHILD'S ID NUMBER BEGINS WITH "1" → Q. 6.

☐ CHILD'S ID NUMBER BEGINS WITH "2" → RECORD END TIME.

6. Are you now using any WIC foods in your home?

Yes 01
No. 02

End Time _____ am
pm

CHILD HEALTH QUESTIONNAIRE

Start Time _____ am / pm

I have some questions about (CHILD'S) health.

1. Was (CHILD) breastfed at any time on a regular basis?

   Yes 01
   No. . . . . 02 } (Q. 2.)
   Don't know. . . . . DK }

   A. How old was (CHILD) when [he/she] stopped breastfeeding?

   ☐☐ Days OR ☐☐ Months

   Still breastfed. . . . 01

2. Compared to other children (CHILD'S) age, would you say [his/her] health is excellent, good, fair, or poor?

   Excellent 01
   Good. 02
   Fair. 03
   Poor. 04

3. Does (CHILD) have a long-lasting physical condition that limits [his/her] ability to walk, run, or play?

   Yes 01
   No. . . . . 02 } (CHECKPOINT B.)
   Don't know. . . . . DK }

   A. What is the condition? RECORD VERBATIM.

   _____

   _____

   _____

   B. Have [you/(CHILD'S) parent] ever sought help about this problem from a doctor, nurse, or other medical person?

   Yes 01
   No. 02
   Don't know. . . . . DK

CHECKPOINT B

☐ Child is less than 3 years old → Q. 5.

☐ Child is 3 years old and older → Q. 4.

4. Does (CHILD) have a long-lasting mental or emotional condition that limits [his/her] ability to learn?

Yes 01
No. 02
Don't know. . . . . DK

5. Has a doctor ever said that (CHILD) had anemia--sometimes called "tired blood" or "low blood"?

Yes 01
No. . . . . 02 } (Q. 6.)
Don't know. . . . . DK }

A. How old was (CHILD) when [he/she] first became anemic (or had "tired blood" or "low blood")?

☐☐ Months OR ☐☐ Years

Don't know/remember. . DK

B. Was (CHILD) treated for anemia by a doctor?

Yes. 01
No . . . . . 02 (Q. 6.)

C. Is [he/she] still being treated for it?

Yes. 01
No 02

6. Children sometimes eat things that are usually not considered food. Has (CHILD) ever eaten clay, starch, paint chips, plaster, printed paper, dirt, or similar things more than just a few times?

Yes 01
No . . . . . 02 } (Q. 7.)
Don't know . . . . . DK }

A. What kinds of things?

(CIRCLE ALL THAT APPLY.)
Clay 01
Dirt 02
Paint chips. 03
Plaster. 04
Printed paper. 05
Starch 06
Other (SPECIFY). . . . 07

_____

7. Has (CHILD) ever been tested for lead poisoning or high lead?

Yes 01
No . . . . . 02 } (Q. 8.)
Don't know . . . . . DK }

A. Did the results indicate that [he/she] had lead poisoning or high lead?

Yes 01
No 02 (Q.8.)

B. Has (CHILD) ever been treated for lead poisoning or high lead?

Yes 01
No 02

8. Has (CHILD) ever been enrolled in the WIC Program?

Yes 01
No. . . . . 02 } (Q. 9.)
Don't know. . . . . DK }

A. Is (CHILD) enrolled in the WIC Program <u>now</u>?

Yes 01
No 02
Don't know . . . . . DK

9. Is there a particular clinic, health center, doctor's office, or other place that (CHILD) usually goes to if (CHILD) is sick or you need advice about [his/her] health?

Yes	01	
No	02	(C.)
Don't know	DK	

A. What kind of place is that--a clinic, a health center, a hospital, a doctor's office, or some other place?

IF HOSPITAL, PROBE: Is that an outpatient clinic or an emergency room?

IF CLINIC, PROBE: Is that a hospital outpatient clinic or some other kind of clinic?

(CIRCLE ONE.)

Doctor's office (group practice or doctor's clinic)	01
Hospital outpatient clinic	02
Health center	03
Hospital emergency room	04
Other	05
Don't know	DK

B. In the last year, has (CHILD) been to the (PLACE) for a routine check-up, shots, or an examination when [he/she] was not sick?

Yes	01	
No	02	(Q. 10.)
Don't know	DK	

C. In the last year, has (CHILD) been to a doctor or other medical person for a routine check-up, shots, or an examination when [he/she] was not sick?

Yes	01
No	02
Don't know	DK

10. ASK FOR CHILD'S IMMUNIZATION CARD: I need to see (CHILD'S) immunization card (or the record of shots [he/she] has had).

(CIRCLE ONE.)

Card available	01
Card not available	02

IF CARD AVAILABLE, ABSTRACT AS MUCH DATA AS POSSIBLE FROM CARD.

IF CARD NOT AVAILABLE OR IF ANY DATA ARE MISSING FROM CARD, ASK Qs. 11 - 13, AS NECESSARY.

11. Has (CHILD) ever had shots to prevent diphtheria, pertussis or whooping cough, and tetanus? These shots are sometimes called DPT shots.

Yes 01
No. . . . . 02 } (Q. 12.)
Don't know. . . . . DK }

CODE SOURCE
RECORD. 01
RESPONDENT. . . 02

A. How old was (CHILD) when [he/she] got the first DPT shot?

☐☐ ☐☐ ☐☐
Month Day Year

CODE SOURCE
RECORD. 01
RESPONDENT. . . 02

OR

☐☐ Months old OR ☐☐ Years old

B. Altogether, how many different times has (CHILD) had a DPT shot?

☐ DPT shots
Don't know . . . . . DK

CODE SOURCE
RECORD. 01
RESPONDENT. . . 02

C. ASK ONLY IF MORE THAN "1" ENTERED IN B:
How old was (CHILD) when [he/she] got the last of the (NUMBER) DPT shots?

☐☐ ☐☐ ☐☐
Month Day Year

CODE SOURCE
RECORD. 01
RESPONDENT. . . 02

OR

☐☐ Months old OR ☐☐ Years old

12. The oral vaccine to prevent polio involves putting drops in a baby's mouth or giving a sugar cube with drops on it to a young child. Has (CHILD) ever had this oral vaccine to prevent polio?

Yes 01
No. . . . . 02 } (Q.13.)
Don't know. . . . . DK }

CODE SOURCE
RECORD. 01
RESPONDENT. . . 02

A. How old was (CHILD) when [he/she] first got the oral polio vaccine?

☐☐ Month ☐☐ Day ☐☐ Year

OR

☐☐ Months old OR ☐☐ Years old

CODE SOURCE
RECORD. 01
RESPONDENT. . . 02

B. Altogether, how many different times has [he/she] had the oral polio vaccine?

☐ Doses of polio vaccine
Don't know . . . . . DK

CODE SOURCE
RECORD. 01
RESPONDENT. . . 02

C. ASK ONLY IF MORE THAN "1" ENTERED IN B: How old was (CHILD) when [he/she] had the last of the (NUMBER) doses of oral polio vaccine?

☐☐ Month ☐☐ Day ☐☐ Year

OR

☐☐ Months old OR ☐☐ Years old

CODE SOURCE
RECORD. 01
RESPONDENT. . . 02

13. Has (CHILD) ever had shots to prevent measles, or a combination of mumps, measles, and Rubella?

Yes 01
No. . . . . 02 } (CHECKPOINT C.)
Don't know. . . . . DK }

CODE SOURCE
RECORD. 01
RESPONDENT. . . 02

A. How old was (CHILD) when he got [his/her] measles (or MMR) shot?

☐☐ Month ☐☐ Day ☐☐ Year

CODE SOURCE
RECORD. 01
RESPONDENT. . . 02

OR

☐☐ Months old OR ☐☐ Years old

CHECKPOINT C

☐ Child is less than 4 years old → RECORD END TIME.

☐ Child is 4 or 5 years old → Q. 14.

14. Is (CHILD) fluent in English?

Yes 01
No. 02

End Time _____ am
pm

OBSERVATION

Respondent's relationship to child.
(CIRCLE ONE.)

Mother 01
Father 02
Brother or sister. . . . 03
Grandparent. 04
Other (SPECIFY). 05

_____

CONTINUE WITH MEASUREMENTS.

(THIS PAGE IS INTENTIONALLY BLANK.)

FOR 4- AND 5-YEAR-OLDS ONLY

PEABODY PICTURE VOCABULARY TEST

ENTER CHILD'S NAME AND ID NUMBER ON ANSWER SHEET.

Hello, my name is _____. I want you to look at some pictures with me.

SET UP PICTURE PLATES AND OPEN TO TRAINING PLATE A.

See all the pictures on this page. (POINT TO EACH PICTURE IN TURN.) I will say a word; then I want you to put your finger on the picture of the word I have said. Let's try one. Put your finger on doll.

- IF THE CHILD MAKES THE CORRECT RESPONSE, SAY: That's fine. TURN TO TRAINING PLATE B. Now put your finger on man.

- IF THE CHILD GIVES AN INCORRECT RESPONSE, POINT OUT THE CORRECT RESPONSE AND SAY: You made a good try, but this is the correct answer.

CONTINUE WITH THE TRAINING SERIES. IF THE CHILD GIVES A CORRECT RESPONSE TO THE INITIAL PRACTICE WORDS ON PLATES A, B, AND C, BEGIN THE TEST WORDS AFTER 3 CONSECUTIVE CORRECT RESPONSES. USE THE ALTERNATE SERIES X, Y, AND Z WORDS UNTIL YOU GET 3 CONSECUTIVE CORRECT RESPONSES.

IF YOU DO NOT GET 3 CONSECUTIVE CORRECT RESPONSES AFTER USING ALL PRACTICE WORDS FOR PLATES A-C, DISCONTINUE THE TEST.

BEGIN TESTING AT ITEM 15 FOR 4-YEAR-OLDS OR AT ITEM 30 FOR 5-YEAR-OLDS. CIRCLE THE ITEM NUMBER WHERE YOU START.

BEGIN BY SAYING: Now I am going to show you some other pictures. Each time I say a word, you find the best picture of it. When we get further along in the book, you may not be sure you know the meaning of the word, but I want you to look carefully at all of the pictures anyway, and choose the one you think is right.

Now, point to (STARTING WORD).

IN THE RESPONSE BLANK AFTER EACH WORD, ENTER THE NUMBER OF THE CHILD'S RESPONSE. IF THE RESPONSE IS INCORRECT, DRAW A DIAGONAL LINE THROUGH THE ITEM (PLATE) NUMBER.

- GIVE PRAISE THROUGH SHORT COMMENTS--Good. That's fine. You are doing well.

- IF THE CHILD ASKS IF HIS/HER ANSWER WAS CORRECT, THE ONLY PERMISSIBLE RESPONSE IS: That was a good answer.

- IF THE CHILD DOES NOT RESPOND AFTER 1 MINUTE, SAY: Try one. Point to the one you think is correct.

- IF THE CHILD WILL NOT RESPOND OR SAYS "DON'T KNOW," RECORD NR (NO RESPONSE) IN THE RESPONSE BLANK BESIDE THE WORD AND DRAW A DIAGONAL LINE THROUGH THE ITEM (PLATE) NUMBER.

- IF THE CHILD REPEATEDLY POINTS TO THE SAME PICTURE QUADRANT, ON A SERIES OF PLATES, SAY: Be sure to look carefully at all four pictures before choosing one.

FROM THE STARTING ITEM, WORK FORWARD UNTIL THE CHILD MAKES THE FIRST ERROR.

- IF 8 OR MORE CONSECUTIVE CORRECT RESPONSES HAVE BEEN GIVEN, A BASAL LEVEL HAS BEEN ESTABLISHED. CONTINUE TESTING UNTIL THE CHILD MAKES 6 ERRORS IN 8 CONSECUTIVE ITEMS; THEN STOP.

- IF THE CHILD GIVES AN INCORRECT RESPONSE BEFORE 8 CONSECUTIVE CORRECT RESPONSES HAVE BEEN GIVEN, DROP BACK TO THE WORD IMMEDIATELY BEFORE THE STARTING ITEM, ADMINISTER IT, AND CONTINUE WORKING BACKWARD UNTIL 8 CONSECUTIVE CORRECT RESPONSES, INCLUDING PREVIOUS CORRECT RESPONSES, HAVE BEEN GIVEN. WHEN THE BASAL LEVEL HAS BEEN ESTABLISHED, TEST FORWARD AGAIN UNTIL THE CHILD MAKES 6 ERRORS IN 8 CONSECUTIVE ITEMS; THEN STOP.

TO TERMINATE THE TEST, SAY: That was very good. Thank you.

CONTINUE WITH NUMERICAL MEMORY TEST.

INTERVIEWER RATING OF MATERNAL BEHAVIOR

(COMPLETE THIS RATING IMMEDIATELY AFTER THE HOME VISIT TO COLLECT DATA ABOUT THIS CHILD.)

1. Overall, how cooperative was the child's mother while you were asking questions, taking measurements, and administering the psychological tests?

   Very cooperative 01
   Cooperative. 02
   Uncooperative. 03
   Very uncooperative 04

2. How responsive was the mother to the child's needs?

   Very responsive. 01
   Responsive 02
   Unresponsive 03
   Very unresponsive. 04

3. How interested was the mother in the child's test performance?

   Very interested. 01
   Interested 02
   Uninterested 03
   Very uninterested. 04

OMB No. 0584-0306
Expires 12/31/83

DIARY PLACEMENT AND PICK-UP QUESTIONNAIRE

A Study of
Health and Nutrition of Mothers and Their Children

Sponsored by

Food and Nutrition Service
U.S. Department of Agriculture

Conducted by

New York State Research Foundation
and
Research Triangle Institute

ID LABEL

DATE OF DIARY PLACEMENT: MONTH ☐☐ DAY ☐☐

DATES OF DIARY PERIOD: FROM MONTH ☐☐ DAY ☐☐ TO MONTH ☐☐ DAY ☐☐

DATE OF DIARY PICK-UP: MONTH ☐☐ DAY ☐☐

FINAL DIARY STATUS

Diary completed by respondent or family unit member 01
Diary completed partially by recall 02
Diary completed totally by recall 03
Diary refused by respondent 04
No one in family unit capable of completing Diary 05
Language barrier 06
Other (SPECIFY) 07

_____

_____

CALENDAR

1983

JANUARY

S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

FEBRUARY

S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28					

MARCH

S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

APRIL

S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

MAY

S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

JUNE

S	M	T	W	T	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30		

JULY

S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

AUGUST

S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

SEPTEMBER

S	M	T	W	T	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	

OCTOBER

S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

NOVEMBER

S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

DECEMBER

S	M	T	W	T	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

SECTION I

INSTRUCTIONS FOR DIARY PLACEMENT

IDENTIFICATION

- IF RESPONDENT IS IN DIARY SAMPLE, PUT ID LABELS FROM ACF ON DIARY AND THIS QUESTIONNAIRE.
- RECORD DATE OF DIARY PLACEMENT, WHICH SHOULD BE THE SAME AS THE FOLLOW-UP INTERVIEW DATE, ON THE COVER OF THIS QUESTIONNAIRE.
- RECORD DATES OF DIARY PERIOD ON THIS QUESTIONNAIRE.
- RECORD DAYS AND DATES OF DIARY PERIOD ON FRONT COVER OF DIARY. (REFER TO CALENDAR ON OPPOSITE PAGE.)

FAMILY UNIT LISTING

- REFER TO HOUSEHOLD ROSTER AS UPDATED DURING FOLLOW-UP INTERVIEW. ENTER NAMES AND AGES OF PERSONS WITH FAMILY UNIT STATUS CODE "1" IN THE HOUSEHOLD LISTING ON PAGE 1 OF THE DIARY.
- READ ALL TEXT ON PAGE 1 TO RESPONDENT, POINTING OUT ENTRIES YOU HAVE MADE.

EXPLANATION

- REVIEW EXAMPLES ON PAGES 2 AND 3 OF DIARY WITH RESPONDENT.
- READ ALL TEXT ON PAGE 4 TO RESPONDENT AND ANSWER ANY QUESTIONS SHE MAY HAVE. POINT OUT DAILY REMINDER LIST ON BACK COVER.
- READ TEXT ON PAGE 5 TO RESPONDENT.
- RECORD YOUR NAME AND PHONE NUMBER PLUS THE DAY AND DATE YOU PLAN TO PICK UP THE DIARY.
- EXPLAIN INCENTIVE AS FOLLOWS: We realize that keeping this record every day will take some time. As a way to express our appreciation to you for keeping this record, I will give you $10 when I pick up your completed record on (DATE).

SAMPLE PAGES

- TURN TO PAGES 6 AND 7 AND SAY TO THE RESPONDENT: Together, let's fill in a few lines on these sample pages so that you can see how to write down the food and beverages that you (and other members of your family unit) buy during the next 7 days.

  Did you (or any members of your family unit) buy any food or beverages yesterday at a grocery store, supermarket, or convenience store?

  IF YES: What did you buy?

  - BEGIN LISTING REPORTED FOODS IN PART 1 ON PAGE 6.
  - PROBE FOR SPECIFIC DESCRIPTIONS, AS NECESSARY.

  IF NO: Think back to the last time you (or a member of your family unit) bought any food or beverages. What did you buy?

  - BEGIN LISTING REPORTED FOODS IN PART 1 ON PAGE 6.
  - PROBE FOR SPECIFIC DESCRIPTIONS, AS NECESSARY.

- ASK FOR EACH REPORTED FOOD/BEVERAGE:

  (1) Was (FOOD) fresh, frozen, bottled or canned, or prepared in some other way?
  MARK AN "X" IN THE PROPER BOX IN COLUMN c.

  (2) How much did (FOOD) cost, not counting any sales tax?
  RECORD COST OF EACH ITEM IN COLUMN d.

- TRY TO RECORD DATA ABOUT 6 OR 8 FOODS AND BEVERAGES IN PART 1 BEFORE CONTINUING WITH PART 2.

  Now, let's write down any meals, snacks, and beverages that you (or any other members of your family unit) have recently bought at restaurants, school or company cafeterias, vending machines, or similar places.

What have you (or other members of your family unit) bought recently?

- BEGIN LISTING REPORTED MEALS/SNACKS IN PART 2 ON PAGE 7.

- PROBE, IF NECESSARY:

  What about...

  school lunches?
  meals at work?
  coffee breaks?
  snacks from vending machines?
  meals eaten away from home?

- ASK FOR EACH REPORTED ITEM:

  (1) What was the total cost of (ITEM) (including tips)?
  RECORD COST OF EACH ITEM IN COLUMN c.

  (2) Were alcoholic beverages included in the total cost?
  MARK AN "X" FOR YES OR NO.

  (3) IF APPLICABLE: How much was the cost of the alcoholic beverage(s)?
  RECORD COST IN COLUMN d.

- TRY TO RECORD DATA ABOUT 3 OR 4 ITEMS IN PART 2 BEFORE CONTINUING.

DIARY PAGES

- Now, let's look at the pages for each of the 7 days that we are asking you to keep this record. I will write the day on the top of the first page for each of the next 7 days.

- TURN TO PAGE 8 AND ENTER THE NAME OF THE FIRST DAY OF THE DIARY PERIOD AT THE TOP OF THE PAGE.

- CONTINUE WITH THE SECOND THROUGH SEVENTH DAYS, SHOWING THE RESPONDENT THE FACING PAGES FOR EACH DAY. REMIND THE RESPONDENT TO WRITE DOWN FOODS AND BEVERAGES PURCHASED EACH DAY ON THE DAY OF PURCHASE.

ADDITIONAL PAGES

- TURN TO PAGE 22.

If you don't have enough lines on the page for a particular day to write down all the foods and beverages that [you/your family unit] bought that day, turn to these pages and use them. Whenever you use one of these pages, you will have to write in the day in this column.

- POINT OUT THE "ENTER DAY" COLUMN.
- TURN TO PAGE 24 AND POINT OUT THE ADDITIONAL PAGE FOR PART 2, NOTING THE "ENTER DAY" COLUMN.

CONCLUSION

- ASK IF RESPONDENT HAS ANY QUESTIONS ABOUT HOW TO USE THE DIARY. CLARIFY, IF NECESSARY.
- LEAVE DIARY WITH RESPONDENT.
- REPEAT DAY AND TIME THAT YOU PLAN TO PICK UP DIARY.
- REMIND RESPONDENT TO CALL YOU IF SHE HAS PROBLEMS OR QUESTIONS. SUGGEST TIMES FOR HER TO CALL WHEN YOU ARE LIKELY TO BE AT HOME.
- THANK RESPONDENT FOR HER COOPERATION.

SECTION II

DIARY CHECKS

FAMILY UNIT CHECK

TURN TO PAGE 1 OF DIARY.

- IF NO "DAYS AWAY" ARE ENTERED FOR ANY FAMILY UNIT MEMBER, ASK Q. 1.
- IF "DAYS AWAY" ARE ENTERED FOR ONE OR MORE FAMILY UNIT MEMBERS, GO TO Q. 2.

1. Were you (or any members of your family unit) away from home overnight or longer during the 7 days from (DAY 1) through (DAY 7)?

   Yes 01
   No . . . . . 02 (VISITOR CHECK.)

   A. Who was away overnight or longer?
   CHECK THE LINE NUMBER OF EACH PERSON WHO WAS AWAY.

   B. ASK FOR EACH PERSON WHO WAS AWAY:
   How many <u>days</u> was (NAME) away from home?
   ENTER NUMBER OF DAYS AWAY FOR EACH PERSON.

   GO TO VISITOR CHECK.

2. Not counting (NAME(S) OF PERSON(S) AWAY), were any <u>other</u> members of your family unit away from home overnight or longer during the 7 days from (DAY 1) through (DAY 7)?

   Yes 01
   No . . . . . 02 (VISITOR CHECK.)

   A. Who was away overnight or longer?
   CHECK THE LINE NUMBER OF EACH PERSON WHO WAS AWAY.

   B. ASK FOR EACH PERSON WHO WAS AWAY:
   How many <u>days</u> was (NAME) away from home?
   ENTER NUMBER OF DAYS AWAY FOR EACH PERSON.

VISITOR CHECK

CHECK "VISITOR BOX" ON PAGE 1 OF DIARY.

- IF NO VISITORS ARE LISTED, ASK Q. 3.
- IF ONE OR MORE VISITORS ARE LISTED, GO TO Q. 4.

3. Did any visitors or guests stay with you overnight or longer during the 7 days from (DAY 1) through (DAY 7)?

   Yes 01
   No . . . . . 02 (CONTENT CHECKS.)

   A. Please tell me the first names and ages of all visitors who stayed overnight or longer (during the 7 days from (DAY 1) through (DAY 7)).
   ENTER NAME AND AGE OF EACH VISITOR IN VISITOR BOX.

   B. ASK FOR EACH VISITOR: How many <u>days</u> did (NAME) stay with you?
   ENTER NUMBER OF DAYS EACH VISITOR STAYED.

   C. Did (any of) the visitor(s) who stayed overnight with you bring or buy any snacks, food, or nonalcoholic beverages for you (and members of your family unit)?

      Yes 01
      No . . . . 02 (CONTENT CHECKS.)

   D. About how much would those foods and beverages have cost if <u>you</u> had bought them?

      $ [ ][ ][ ] (CONTENT CHECKS.)

4. Not counting (NAME(S) OF VISITOR(S) LISTED), did any <u>other</u> visitors or guests stay with you overnight or longer during the 7 days from (DAY 1) through (DAY 7)?

   Yes 01
   No . . . . . 02 (GO TO C.)

4. A. Please tell me the first names and ages of the other visitors who stayed overnight or longer (during the 7 days from (DAY 1) through (DAY 7)).
ENTER NAME AND AGE OF EACH VISITOR IN VISITOR BOX.

B. ASK FOR EACH VISITOR: How many days did (NAME) stay with you?
ENTER NUMBER OF DAYS EACH VISITOR STAYED.

C. Did any of the visitors who stayed overnight with you bring or buy any snacks, food, or nonalcoholic beverages for you (and members of your family unit)?

Yes 01
No . . . . 02 (CONTENT CHECKS.)

D. About how much would those foods and beverages have cost if you had bought them?

$ [| |] (CONTENT CHECKS.)

CONTENT CHECKS

ARE THERE ANY COMPLETELY BLANK DAY PAGES?

Yes 01
No . . . . . 02 (Q. 6.)

5. ASK FOR EACH SET OF BLANK DAY PAGES: Did you (or any members of your family unit) buy any food, beverages, or snacks on (DAY)?

Yes 01
No . . . . . 02 (CODE "NO FOOD PURCHASED" AT TOP OF PAGE. GO TO Q. 6.)

A. What did you (or others) buy on (DAY)? LIST REPORTED FOODS IN PART 1 OR PART 2, AS APPROPRIATE. PROBE FOR NECESSARY DETAIL. COMPLETE COLUMNS c AND d FOR EACH ITEM REPORTED.

B. IF RESPONDENT CANNOT RECALL FOODS/BEVERAGES PURCHASED ON A CERTAIN DAY, CODE "DIARY NOT KEPT" AT TOP OF PAGE AND GO TO Q. 6.

6. REVIEW EACH SET OF DAY PAGES AND MAKE THE FOLLOWING CHECKS:

- ARE ALL ENTRIES LEGIBLE? IF NOT, CLEAN UP ORIGINAL ENTRY OR LINE THROUGH ORIGINAL ENTRY AND TRANSCRIBE ALL DATA TO NEXT AVAILABLE LINE.

- IS A "REASONABLE" TOTAL COST ENTERED FOR EACH ITEM? IF TOTAL COST SEEMS HIGH OR LOW, VERIFY WITH RESPONDENT.

- IN PART 1, IS THERE AN "X" IN COLUMN c FOR EACH ITEM? IF NOT, ASK RESPONDENT AND MARK COLUMN c.

- IN PART 2, IF "YES" IS MARKED IN COLUMN d, IS AN AMOUNT ALSO RECORDED? IF NOT, ASK AND RECORD THE COST OF ALCOHOLIC BEVERAGES.

- IS ADEQUATE DETAIL ENTERED FOR THE FOLLOWING FOODS? IF NOT, PROBE FOR AND RECORD SPECIFIC DESCRIPTIONS.

  MILK - Describe as whole milk, skim milk, 2% milk, condensed milk, evaporated milk, or powdered milk.

  BREAD - Describe as white bread, whole wheat bread, rye bread, or other specific type.

  BEEF - Describe the type, such as beef ribs, ground beef or hamburger, round steak, or other cut or type.

  PORK - Describe the type, such as spare ribs, loin chops, bacon, sausage, fresh ham, smoked ham, or other cut or type.

  CHICKEN - Describe as whole chicken or chicken parts, such as legs, wings, breasts, or other pieces.

  SOFT DRINKS - Write down the brand name and type, such as Tab, Coca-Cola, Diet 7-Up, Dr. Pepper, Diet Pepsi Cola, Chek Grape Soda, or other brands.

  COFFEE - Describe as regular (ground) or instant coffee. Include "freeze-dried" coffee as instant coffee.

7. We have found that certain types of food and beverage costs are sometimes forgotten. I would like to ask about a few types of costs.

A. First, did you (or anyone in your family unit) buy any staples--such as flour, sugar, salt, or shortening--during the past week that are not recorded in this record?

Yes	01	(ASK WHAT ITEMS WERE BOUGHT; RECORD ALL REQUIRED DETAIL ON APPROPRIATE DAY PAGES.)
No	02	(B.)

B. During the past week, did you (or anyone in your family unit) buy any milk, cheese, eggs, cereal, or juice that are not recorded in this record?

Yes	01	(ASK WHAT ITEMS WERE BOUGHT; RECORD ALL REQUIRED DETAIL ON APPROPRIATE DAY PAGES.)
No	02	(C.)

C. During the past week, did you (or anyone in your family unit) buy any food or beverages in restaurants, cafeterias, cafes, drive-ins, vending machines, or other such places that are not recorded in this record?

Yes	01	(ASK WHAT ITEMS WERE BOUGHT; RECORD ALL REQUIRED DETAIL ON APPROPRIATE DAY PAGES.)
No	02	(D.)

D. Did you (or any members of your family unit) buy any food with Food Stamps, WIC vouchers, or benefits from other food programs during the past week that are not recorded in this record?

Yes	01	(ASK WHAT ITEMS WERE BOUGHT; RECORD ALL REQUIRED DETAIL ON APPROPRIATE DAY PAGES.)
No	02	(8.)

IF RESPONDENT LIVES ALONE, GO TO CONCLUSION.

8. Were you the <u>main</u> person who kept this record or did some other member of your family unit keep this record?

Respondent . . . . . 01 (CONCLUSION.)
Other family unit member . . 02 (A.)
Combination of respondent and other(s) . . . . . 03 (CONCLUSION.)

A. Who was the main person (who kept this record)?

FIRST NAME _____

RELATIONSHIP TO RESPONDENT _____

CONCLUSION

Thank you very much for your help on this important part of our research study.

- RETRIEVE DIARY.
- PREPARE RECEIPT AND HAVE RESPONDENT SIGN IT.
- PAY $10 INCENTIVE TO RESPONDENT.
- CODE FINAL DIARY STATUS ON COVER OF THIS QUESTIONNAIRE.

OMB No. 0584-0306
Expires 12/31/83

WOMEN'S FOLLOW-UP INTERVIEW PACKAGE

A Study of
Health and Nutrition of Mothers and Their Children

Sponsored by

Food and Nutrition Service
U.S. Department of Agriculture

Conducted by

New York State Research Foundation
and
Research Triangle Institute

FOLLOW-UP INTERVIEW PACKAGE LABEL

RESPONDENT NAME (FIRST, MIDDLE, LAST)				
STREET ADDRESS				APT. NO.
CITY/TOWN/VILLAGE		COUNTY	STATE	ZIP
PSU #	CLINIC #	OPERATIVE NAME		ID #

INSTRUCTIONS

- COMPLETE DIETARY INTERVIEW IF SAMPLING MESSAGE ON ACF READS "IN DIETARY INTERVIEW SAMPLE."
- CONTINUE WITH FOLLOW-UP QUESTIONNAIRE
- TAKE MEASUREMENTS AND RECORD ON MEASUREMENT FORM.
- IF RESPONDENT IS IN DIARY SAMPLE, EXPLAIN THE DIARY AND SCHEDULE AN APPOINTMENT FOR PICK-UP.

Start Time _____ am
pm

WOMEN'S DIETARY INTERVIEW

(24-HOUR RECALL)

DATE COMPLETED

Month	Day	Year

DAY OF WEEK

Monday 01
Tuesday. 02
Wednesday. . . . 03
Thursday 04
Friday 05
Saturday 06
Sunday 07

MEASUREMENT CONVERSIONS

3 teaspoons = 1 tablespoon
2 tablespoons = 1 fluid ounce
4 tablespoons = ¼ cup
5 1/3 tablespoons = 1/3 cup
16 tablespoons = 1 cup = 8 ounces = ½ pint
2 cups = 1 pint
2 pints = 1 quart

NOTES:

MILK
MILK PRODUCTS

	WORKSPACE	TOTAL AMOUNT			CODE
Whole Milk				oz	001
Skim Milk				oz	002
1% Milk				oz	003
2% Milk				oz	004
Buttermilk				oz	005
Chocolate Milk				oz	006
Hot Chocolate/Cocoa				oz	007
Evaporated Milk				oz	008
Nonfat Dry Milk, Prepared				oz	009
Ice Cream Flavors, Not Chocolate				C	010
Ice Cream, Chocolate				C	011
Sugar Cone				ea	012
Pudding, Chocolate Mix				C	013
Pudding, Vanilla Mix				C	014
Yogurt, Plain, Low Fat				C	015
Yogurt, Fruit, Low Fat				C	016
American Processed Cheese					017
American Cheese Food					018
American Cheese Food Spread				T	019
Cheddar/Brick Cheese					020
Colby Cheese					021
Cottage Cheese				C	022
Monterey Jack Cheese					023
Mozzarella Cheese					024
Muenster Cheese					025
Parmesan Cheese, Grated				t	026
Provolone Cheese					027
Swiss Cheese					028
Other:					

NOTES: _____

MEAT
POULTRY
EGGS

	WORKSPACE	TOTAL AMOUNT	CODE
Beef/Veal/Lamb:			
Beef, Ground/Hamburger			029
Corned Beef/Pastrami			030
Lamb			031
Meatloaf/Meatballs			032
Pot Roast			033
Ribs, Braised			034
Roast Beef			035
Salisbury Steak			036
Steak, Broiled, Fat Trimmed			037
Steak, Broiled, Fat Not Trimmed			038
Steak, Fried			039
Veal, Chop or Roast			040
Veal Cutlet, Fried			041
Pork:			
Bacon		sl	042
Chops/Steak			043
Ham, Cured			044
Ham Hocks		ea	045
Ham Salad		T	046
Pork, Neckbones		ea	047
Pork, Pigs Feet, Pickled		ea	048
Pork Roast			049
Spareribs, Braised			050
Sausages and Luncheon Meats:			
Beef, Pressed			051
Bologna, All Kinds			052
Deviled Ham/Spam		T	053
Frankfurter, All Kinds		ea	054
Ham, Boiled, Lunchmeat			055
Liverwurst			056
Luncheon Loaf w/Olive, Pickle, Pimento			057
Polish/Italian Sausage			058
Pork Sausage			059
Salami/Pepperoni/Summer Sausage			060
Poultry and Eggs:			
Chicken Breast, Fried		ea	061
Chicken Drumstick, Fried		ea	062
Chicken Thigh, Fried		ea	063
Chicken Wing, Fried		ea	064
Chicken/Turkey, Roast w/ Skin			065
Chicken/Turkey, Roast w/o Skin			066
Eggs, Scrambled		ea	067
Eggs, Hard or Soft Cooked, Poached or Fried		ea	068
Egg Salad		T	069
Other:			

FISH & SEAFOOD
MEAT ALTERNATES
SOUPS

	WORKSPACE	TOTAL AMOUNT	CODE
Fish and Seafood:			
Cod/Flounder, Baked			070
Cod, Salt			071
Fish/Catfish, Fried			072
Fish Sticks			073
Haddock, Broiled			074
Shrimp, Canned		C	075
Shrimp, Fried		C	076
Tuna, Canned in Oil, Drained Solids		C	077
Tuna, Canned in Water		C	078
Tuna Salad		T	079
Meat Alternates:			
Beans, Black, Cooked		C	080
Beans, Fried/Refried, Cooked		C	081
Beans, Garbanzo/Chick Peas, Cooked		C	082
Beans, Lima, Mature, Cooked		C	083
Beans, Pinto/Calico, Cooked		C	084
Beans, Red/Kidney, Cooked		C	085
Beans. White/Navy, Cooked		C	086
Lentils, Cooked		C	087
Peanut Butter		T	088
Peanuts		T	089
Peas, Blackeyed/Cowpeas, Cooked		C	090
Peas, Split, Cooked		C	091
Soups (Ready-To-Serve):			
Bean		C	092
Broth/Consommé, Beef, Canned		C	093
Broth/Consommé, Chicken, Canned		C	094
Chicken Noodle		C	095
Chicken Rice		C	096
Codfish Soup w/Noodles, Puerto Rican Style		C	097
Cream of Chicken		C	098
Cream of Mushroom		C	099
Cream of Potato		C	100
Cream of Tomato		C	101
Fish Chowder		C	102
Tomato		C	103
Vegetable Beef		C	104
Vegetable Noodle		C	105
Vegetarian Vegetable		C	106
Other:			

CASSEROLES
HONEY, SUGAR, SYRUP
CONDIMENTS

	WORKSPACE	TOTAL AMOUNT	CODE
Casseroles and Combinations (Ready-To-Serve):			
Beef and Vegetable Stew		C	107
Beef, Ground w/Vegetables Casserole		C	108
Beef, Pot Pie, 4"		ea	109
Burritos (Tortilla, Meat, Refried Beans)		ea	110
Chicken and Dumplings		C	111
Chicken/Turkey Pot Pie, 4"		ea	112
Chili Con Carne w/Beans		C	113
Chili Con Carne w/o Beans		C	114
Goulash, Beef w/Noodles		C	115
Lasagna			116
Macaroni and Cheese		C	117
Macaroni w/Chicken		C	118
Macaroni w/Tuna		C	119
Pizza, Cheese			120
Pizza, Meat & Cheese			121
Pork and Beans		C	122
Ravioli, w/Meat		C	123
Spaghetti, Meat & Tomato Sauce		C	124
Spaghetti, Cheese & Tomato Sauce			125
Honey, Sugar, Syrup:			
Honey		t	126
Jams/Jellies		t	127
Sugar		t	128
Molasses		t	129
Chocolate Syrup, Thin Type		t	130
Chocolate Topping, Thick Fudge Type		t	131
Chocolate Powder		t	132
Pancake Syrup		t	133
Condiments:			
B-B-Q Sauce		t	134
Catsup		t	135
Mustard		t	136
Pickle, Dill, 3 3/4" Long x 1 1/4" Thick		ea	137
Pickle Relish		t	138
Pickle, Sweet, 2 1/2" Long x 3/4 " Thick		ea	139
Tomato Chili Sauce		t	140
Other:			

FRUIT
FRUIT JUICE

	WORKSPACE	TOTAL AMOUNT	CODE
Apple, Baked w/Sugar		ea	141
Apple Juice		oz	142
Apple, Raw		ea	143
Apple Sauce		C	144
Apricots, Canned, Heavy Syrup		C	145
Avocado, Raw		ea	146
Banana, Raw		ea	147
Cantelope, Raw		C	148
Cranberry Juice		oz	149
Cranberry Sauce		T	150
Fruit Cocktail, Canned, Heavy Syrup		C	151
Grapefruit Juice		oz	152
Grapefruit, Raw		ea	153
Grape Juice		oz	154
Grapes, Raw		C	155
Lemon Juice		t	156
Lemon, Raw		sl	157
Orange Juice		oz	158
Orange, Raw		ea	159
Orange-Grapefruit Juice		oz	160
Peaches, Canned, Heavy Syrup		C	161
Peach, Raw		ea	162
Pineapple, Canned, Heavy Syrup		C	163
Pineapple Juice		oz	164
Plum, Raw		ea	165
Prune, Dried		ea	166
Raisins		T	167
Strawberries, Raw		C	168
Tangelos/Tangerines, Raw		ea	169
Watermelon, Raw		C	170
Other:			

NOTES: _____

VEGETABLES

	WORKSPACE	TOTAL AMOUNT	CODE
Asparagus, Cooked		C	171
Beans, Baby Limas, Cooked		C	172
Beans, Green or Yellow Snap		C	173
Bean Sprouts, Raw		C	174
Beets, Cooked		C	175
Broccoli, Cooked		C	176
Brussel Sprouts, Cooked		C	177
Cabbage, Cooked		C	178
Carrots, Cooked		C	179
Carrots, Raw		ea	180
Cauliflower, Cooked		C	181
Celery Stalk, Raw		ea	182
Coleslaw, All Types		C	183
Collard Greens, Cooked		C	184
Corn on Cob, Cooked, Ear		ea	185
Corn, Cream Style, Cooked		C	186
Corn, White Kernel, Cooked		C	187
Cucumbers, Raw		ea	188
Lettuce, Head & Leaf		C	189
Mixed Vegetables, Cooked		C	190
Mushrooms, Cooked		C	191
Mustard/Turnip Greens, Cooked		C	192
Okra, Cooked		C	193
Onions, Green/Scallions, Raw		ea	194
Onions, Mature, Raw		C	195
Peas, Green, Cooked		C	196
Peas and Carrots, Cooked		C	197
Peppers, Sweet Green, Raw		C	198
Potatoes, Au Gratin		C	199
Potatoes, Baked in Skin		ea	200
Potatoes, Boiled		ea	201
Potatoes, Creamed/Scalloped		C	202
Potatoes, Hash Browns/Home Fries		C	203
Potatoes, French Fried		C	204
Potatoes, Mashed		C	205
Potato Salad		C	206
Radishes, Raw		ea	207
Salad, Tossed (Lettuce & Tomato)		C	208
Sauerkraut		C	209
Spinach, Cooked		C	210
Squash, Summer/Zucchini, Cooked		C	211
Squash, Winter		C	212
Sweet Potatoes, Baked		ea	213
Sweet Potatoes, Candied		C	214
Tomatoes, Canned		C	215
Tomatoes, Raw		ea	216
Tomato Sauce		C	217
Turnips, Cooked		C	218
Other:			

	WORKSPACE	TOTAL AMOUNT	CODE
Bread Stuffing/Dressing		C	219
Breadcrumbs, Dry (Commercial)		T	220
Breads:			
Bagels		ea	221
Biscuits		ea	222
Cornbread			223
English Muffin		ea	224
French Bread (2½" wide)		sl	225
Hamburger/Frankfurter Bun		ea	226
Muffin, Blueberry		ea	227
Rolls:			
Cinnamon Bun		ea	228
Dinner/Soft, Brown'Serve		ea	229
Hard/Kaiser		ea	230
Hoagie/Submarine (11½" x 3" x 2½")		ea	231
Rye Bread		sl	232
White Bread		sl	233
Wheat Bread		sl	234
Corngrits/Hominy Grits		C	235
Cornbread Stuffing/Dressing		C	236
Crackers:			
Butter		ea	237
Graham		ea	238
Soda/Saltines, 2" Square		ea	239
Wheat		ea	240
Croutons, Plain, Toasted		T	241
French Toast, Plain, Homemade		sl	242
Macaroni/Noodles, Cooked		C	243
Pancakes, Waffles			244
Rice, Brown, Cooked		C	245
Rice, Fried, Cooked		C	246
Rice, White, Cooked		C	247
Rice, Spanish, Cooked		C	248
Spaghetti, Plain, Cooked		C	249
Spoonbread		C	250
Tortilla, Corn		ea	251
Tortilla, Wheat		ea	252
Other:			

NOTES: _____

_____

_____

CEREALS
BEVERAGES

	WORKSPACE	TOTAL AMOUNT	CODE
Cereals:			
All Bran/Bran Buds		C	253
Body Buddies		C	254
Bran Flakes, 40% Kellogs		C	255
Cap'n Crunch		C	256
Cheerios		C	257
Corn Flakes, Not Country		C	258
Corn, Puffed (Kix)		C	259
Country Corn Flakes/Corn Total		C	260
Cream of Wheat, Regular		C	261
Cream of Wheat, Mix and Eat		C	262
Cream of Wheat, Mix and Eat, Flavored		C	263
Fruit Loops/Trix		C	264
Granola-type Cereals		C	265
Kaboom		C	266
King Vitamin		C	267
Malt-O-Meal, Chocolate & Plain		C	268
Maypo		C	269
Most		C	270
Oat Flakes, Fortified		C	271
Oatmeal		C	272
Product 19		C	273
Raisin Bran		C	274
Rice Krispies/Rice, Frosted/Sugar Corn Pops		C	275
Rice, Puffed		C	276
Sugar Frosted Flakes/Sugar Smacks		C	277
Total		C	278
Wheat, Shredded		C	279
Wheaties		C	280
Alcoholic Beverages:			
Beer		oz	281
Beer, Lite		oz	282
Dessert Wine/Sherry/Vermouth		oz	283
Wine, Table		oz	284
Whiskey/Spirits		oz	285
Nonalcoholic Beverages:			
Chocolate/Malted Milk Drink		oz	286
Coffee		oz	287
Hawaiian Punch (w/Vitamin C)		oz	288
Hi-C Fruit Drink (w/Vitamin C)		oz	289
Koolaid (w/Vitamin C)		oz	290
Lemonade		oz	291
Orange Drink/Pineapple Orange Drink		oz	292
Soda, Diet		oz	293
Soda, Regular		oz	294
Tea		oz	295
Tea, Premade w/Lemon & Sugar		oz	296
Other:			

1. Is what you ate yesterday the way you usually eat?

Yes . . . . . 01 (Q. 2.)
No. 02

A. Why was what you ate yesterday different?

Illness. 01
No money 02
Sunday or holiday. 03
Other (SPECIFY). 04

_____

_____

2. Are you on a special diet?

Yes 01
No. . . . . 02 (Q. 3.)

A. Why are you on this diet?

(CIRCLE ALL THAT APPLY.)

Lose weight. 01
Gain weight. 02
Diabetes 03
Kidney failure 04
Ulcers 05
Diverticulitis 06
Allergies. 07
Heart trouble. 08
High blood pressure. 09
Pregnancy. 10
Other (SPECIFY). 11

_____

B. What kind of diet is it?

(CIRCLE ALL THAT APPLY.)

Low calorie or weight reduction. . 01
Low fat. 02
Low protein. 03
High protein 04
Low salt 05
Low carbohydrate 06
Low sugar. 07
High calorie 08
Low cholesterol. 09
Vegetarian with animal by-products (eggs, dairy, etc.) . . 10
Vegetarian without animal by-products 11
Bland diet 12
Other (SPECIFY). 13

_____

3. Are you taking any vitamins or minerals?

Yes 01
No. . . . . 02 (Q. 4.)

A. What brand and type of vitamin or mineral supplements do you take? ENTER BRAND NAME AND DESCRIPTION IN TABLE. SHOW VITAMIN/MINERAL BOOKLET, IF NECESSARY, TO DETERMINE BRAND.

B. How often do you take (NAME/DESCRIPTION)? ENTER TIMES IN TABLE.

C. (ASK IF NECESSARY:) Is that per day or some other interval? ENTER INTERVAL IN TABLE.

D. Was this prescribed or recommended by a medical person? CODE "YES" OR "NO" IN TABLE

	A	B	C	D
	BRAND NAME AND DESCRIPTION	TIMES	INTERVAL	PRESCRIBED OR RECOMMENDED?
(1)				Yes . . . 01 No. . . . 02
(2)				Yes . . . 01 No. . . . 02
(3)				Yes . . . 01 No. . . . 02
(4)				Yes . . . 01 No. . . . 02

4. Were you advised to take any vitamin or mineral supplements that you do not take?

Yes 01
No. 02
Don't know/remember . . . . DK

End Time _____ am
pm

CONTINUE WITH FOLLOW-UP QUESTIONNAIRE.

WOMEN'S FOLLOW-UP QUESTIONNAIRE

Start Time _____ am
pm

A. CURRENT PREGNANCY

A-1. How many visits have you made for medical care during this pregnancy (not counting today's visit)?

☐☐ Visits

Don't know . . . . . DK

A-2. Where have you usually gone to get medical care during this pregnancy?

(CIRCLE ONE.)

Doctor's office (group practice or doctor's clinic). 01
Hospital outpatient clinic 02
Health center. 03
Hospital emergency room. 04
Company/industry clinic. 05
Patient's home 06
Other. 07
Don't know . . . . . DK

A-3. Would you say that it has been very difficult, fairly difficult, or not difficult at all...

		VERY DIFFICULT	FAIRLY DIFFICULT	NOT DIFFICULT AT ALL	NOT APPLICABLE
A.	Getting an appointment to see a doctor or other medical person at (PLACE)?	01	02	03	NA
B.	Arranging to get to (PLACE) when it is open?	01	02	03	NA
C.	Getting to and from (PLACE)?	01	02	03	NA
D.	Having your children taken care of so that you can get your medical care?	01	02	03	NA
E.	Paying for transportation costs to and from (PLACE)?	01	02	03	NA
F.	Paying for prenatal care you get at (PLACE)?	01	02	03	NA

A-4. Are you now covered by...

	YES	NO	DON'T KNOW
A. Medicaid (which is also called (STATE NAME FOR MEDICAID)?	01	02	DK
B. Private health insurance, such as Blue Cross/Blue Shield, or some other plan?	01	02	DK
C. Membership in a health maintenance organization (HMO) or prepaid health plan (PHP)?	01	02	DK
D. Any other type of health insurance plan or program?	01	02	DK

A-5. Do you receive any medical care at a reduced cost from a clinic or hospital?

Yes 01
No 02
Don't know . . . . . DK

A-6. Where do you plan to deliver this baby?

FACILITY NAME _____

CITY _____

COUNTY _____

STATE _____

Don't know . . . . . DK

A-7. Do you currently smoke one or more cigarettes a day?

Yes 01
No 02 (A-8.)

A. About how many cigarettes do you currently smoke a day?

☐☐ Cigarettes per day

A-8. In an average week, on how many days do you drink (BEVERAGE)? ENTER NUMBER OF DAYS IN TABLE. IF NONE, ENTER "0."

A. ASK FOR EACH BEVERAGE CONSUMED: On the days that you drink (BEVERAGE), how many (SPECIFIED MEASURE) do you usually drink? ENTER NUMBER IN TABLE.

BEVERAGE	DAYS PER WEEK	NUMBER	MEASURE
(1) Tea			6 oz. cups or glasses
(2) Coffee			6 oz. cups
(3) Table wine			4 oz. glasses
(4) Sherry, vermouth or dessert wine			2 oz. glasses
(5) Beer or alcoholic malta			12 oz. cans/bottles
(6) Mixed drinks, whiskey, or other liquors			1½ oz. shots

A-9. People sometimes eat things that are usually not considered food. During this pregnancy, have you eaten starch, soap, dirt, clay, or anything else that is usually not considered food?

Yes 01
No 02 (A-10.)

A. What kinds of things?

(CIRCLE ALL THAT APPLY.)
Clay 01
Dirt 02
Soap 03
Starch 04
Other (SPECIFY) 05

_____

A-10. Have you had any illnesses or complications during this pregnancy?

Yes 01
No 02 (A-11.)

A. What kinds of illnesses or complications? RECORD VERBATIM.

(1) _____
(2) _____
(3) _____
(4) _____
(5) _____

A-11. Have you had any vomiting during this pregnancy?

Yes. 01
No 02 (A-12.)

A. About how many days altogether have you had vomiting?

☐☐☐ Days

A-12. Have you had severe nausea during this pregnancy--that is, have you felt sick without vomiting?

Yes. 01
No 02 (A-13.)

A. About how many days altogether have you had severe nausea?

☐☐☐ Days

A-13. Has anyone talked to you at any time during this pregnancy about how much and what kinds of foods you should be eating?

Yes. 01
No 02 (A-14.)

A. Who was that?

(CIRCLE ALL THAT APPLY.)

WIC staff member. 01
Non-WIC health care staff . . 02
Other (SPECIFY) 03

_____

B. How many different times have you received advice or instruction from any clinic staff or other medical people about how much and what to eat during your pregnancy?

☐☐ Times

None. 00 (A-14.)

C. Has this advice or instruction had any effect on the amounts or kinds of food you have eaten during this pregnancy?

Yes 01
No. 02

A-14. Have you decided how you will feed your baby?

Yes. 01
No 02 (A-15.)

A. How do you plan to feed your baby?

Breastfeeding 01
Bottle and formula. 02
Combination 03
Other (SPECIFY) 04

_____

B. What are your reasons for choosing this method? RECORD VERBATIM.

_____

_____

_____

A-15. Has anyone talked to you at any time during this pregnancy about how to feed your baby?

Yes. 01
No . . . . . 02 (CHECKPOINT A.)

A. Who was that?

(CIRCLE ALL THAT APPLY.)
WIC staff member. 01
Non-WIC health care staff . . 02
Other (SPECIFY) 03

_____

B. Did this advice or instruction include a recommendation for a particular feeding method?

Yes 01
No. . . . . 02 (CHECKPOINT A.)

C. What method was recommended to you?

Breastfeeding 01
Bottle and formula. 02
Combination of methods by
one source 03
Combination of methods by
several sources 04
Other (SPECIFY) 05

_____

CHECKPOINT A

☐ Respondent ID number begins with "1" → SECTION B.

☐ Respondent ID number begins with "2" → Q. A-16.

A-16. Have you applied for WIC benefits during this pregnancy?

Yes 01
No . . . . . 02 (SECTION B.)

A. Were you certified eligible to receive WIC benefits?

Yes 01
No. . . . . 02 (SECTION B.)

B. How many months have you received WIC benefits?

☐☐ Months

Less than 1 month. 01
On waiting list, benefits
not yet received 02

B. HOUSING CHARACTERISTICS

My next questions are about the house or apartment where you live, which I will refer to as your living quarters.

B-1. How many rooms do you have in your living quarters, not counting bathrooms, porches, balconies, foyers, halls, or half rooms?

☐☐ Rooms

B-2. Do you have complete kitchen facilities in your living quarters, including a sink with piped water, a range or cookstove, and a refrigerator?

Yes 01
No 02 (B-3.)

A. Do you share these kitchen facilities with members of another household?

Yes 01
No. 02

B-3. Do you have complete plumbing facilities in your living quarters--that is, hot and cold piped water, a flush toilet, and a bathtub or shower?

Yes. 01
No 02 (B-4.)

A. Do you share these plumbing facilities with members of another household?

Yes 01
No. 02

B-4. Do you (or a member of your household) own your living quarters, do you rent your living quarters, or do you live there without paying any rent?

Own. 01
Rent for cash. 02
Occupy without paying rent 03

(THIS PAGE IS INTENTIONALLY BLANK.)

C. CURRENT OCCUPATION

C-1. Are you currently working for pay either full-time or part-time, or are you unemployed, a housewife, a student, or what?

Working.	01	
Temporarily laid off	02	(CHECKPOINT B.)
Unemployed	03	
Permanently disabled	04	
Housewife.	05	
Student.	06	
Other (SPECIFY).	07	

_____

_____

A. How many hours a week do you usually work?

☐☐ Hours

B. Does your present job require heavy physical work, moderate physical work, or little or no physical work?

Heavy physical work	01
Moderate physical work. . . .	02
Little or no physical work. .	03

C. At your present job, do you spend most, part, little, or none of the time standing on your feet?

Most.	01
Part.	02
Little.	03
None.	04

CHECKPOINT B

☐ Respondent ID number begins with "1" → SECTION D.

☐ Respondent ID number begins with "2" → SECTION E., PAGE 26.

D. WIC SERVICES

D-1. Which did you seek first--WIC services or prenatal care?

WIC services 01
Prenatal care. 02
Both at same time. 03

D-2. Did the WIC staff tell you what medical services were available to you during your pregnancy?

Yes. 01
No 02

D-3. Did the WIC staff help you make any appointments to get medical care during your pregnancy?

Yes. 01
No 02

D-4. About how many minutes does it take you to get from your home to the WIC office?

Minutes

D-5. Would you say that it has been very difficult, fairly difficult, or not difficult at all...

	VERY DIFFICULT	FAIRLY DIFFICULT	NOT DIFFICULT AT ALL	NOT APPLICABLE
A. Arranging to get to the WIC office when it is open?	01	02	03	NA
B. Getting to and from the WIC office?	01	02	03	NA
C. Having your children taken care of so that you can come to the WIC office?	01	02	03	NA
D. Paying for transportation costs to and from the WIC office?	01	02	03	NA

E-3. The next questions are about your usual food expenses. (During this part of the interview, I will use the term "family unit" to indicate the person or group of persons in your household who share(s) responsibility for certain major expenses, such as food. The person(s) I'm including in your family unit are you and (NAMES OF ALL PERSONS IN HOUSEHOLD ROSTER WITH FAMILY UNIT STATUS CODE "1").)

Were you (or any members of your family unit) away from home overnight or longer, for one day or more, during the past month?

Yes. 01
No 02 (E-4.)

A. Which person(s)? ENTER FIRST NAMES IN TABLE.

B. How many nights in all was (NAME) away during the past month? ENTER NUMBER OF NIGHTS AWAY FOR EACH PERSON.

NAME	NIGHTS AWAY

E-4. Did any visitors or guests stay with you overnight or longer (for one day or more) during the past month, not counting people who usually live here?

Yes. 01
No 02 (E-5.)

A. How many such persons? ENTER NUMBER OF PERSONS FOR EACH VISIT.

B. How many nights did they stay? ENTER NUMBER OF NIGHTS FOR EACH VISIT.

	NUMBER OF PERSONS	NUMBER OF NIGHTS
VISIT 1		
VISIT 2		
VISIT 3		
VISIT 4		
VISIT 5		
VISIT 6		

E-5. Now I have some questions about the amount of money you (and your family unit) spend for food. First, think about all the times that you (or other members of your family unit) shopped at a grocery store or supermarket during the past month.

During the past month, what was the total amount of your (family unit's) purchases at the grocery store or supermarket? Include purchases made with food stamps, WIC vouchers, or benefits from other food programs.

$ [| |]

None. 00 (E-6.)

A. About how much of this amount was for non-food items, such as paper products, detergents, home cleaning supplies, pet foods, and alcoholic beverages?

$ [| |]

B. Is (AMOUNT IN E-5.) about what you usually spend per month at the grocery store or supermarket?

Yes 01 (E-6.)
No. 02

C. What would you say is a more typical figure?

$ [| |]

E-6. During the past month have you (or any members of your family unit) purchased any food or nonalcoholic beverages from places other than grocery stores, such as convenience stores, dairy stores, specialty stores, bakeries, vegetable stands, farmers' markets, or home delivery? Include any large purchases made for freezing or canning.

Yes. 01
No 02 (E-7.)

A. What was your (family unit's) total monthly expense at these places, excluding purchases of non-food items and alcoholic beverages?

$ [| |]

E-7. During the past month, have you (or any members of your family unit) bought any meals or snacks in restaurants, cafeterias, cafes, drive-ins, vending machines, or other such places?

Yes. 01
No 02 (E-8.)

A. What was the total amount spent for these purchases during the past month, not counting beer, wines, and other alcoholic beverages?

$ [| |]

E-8. During the past month, have you (or any members of your family unit) made any large or bulk purchases of meat, fruit, or vegetables for home freezing or canning?

Yes. 01
No 02 (E-9.)

A. What was the total cost, including charges for cutting, wrapping, and freezing?

$ ☐☐☐

B. Have you eaten any of that food yet?

Yes 01
No. 02 (E-9.)

C. About how much of that food did you eat during the past month? Would you say half of it (50%), a third (33%), one-fourth (25%), 10 percent, or what?

☐☐☐ %

E-9. (Other than last month) during the past <u>six</u> months, have you (or any members of your family unit) made any large or bulk purchases of meat, fruit, or vegetables for home freezing or canning?

Yes. 01
No 02 (E-10.)

A. What was the total cost of that food, including charges for cutting, wrapping, and freezing?

$ ☐☐☐

B. Have you eaten any of that food yet?

Yes 01
No. 02 (E-10.)

C. About how much of that food did you eat during the past month? Would you say half of it (50%), a third (33%), one-fourth (25%), 10 percent, or what?

☐☐☐ %

E-10. During the past month, have you (or any members of your family unit) eaten any fresh, frozen, or canned food that you raised yourself or that was raised by a friend or relative?

Yes. 01
No 02 (E-11.)

A. About how much would this food have cost if you bought it in a store?

$ ☐☐☐

E-11. During the past month, would you say that [you/your family unit] spent more, less or about the same on food and nonalcoholic beverages than during the month before your last interview on (REF. DATE)?

More 01
Less . . . . . 02 (C.)
About the same 03 (E-12.)

A. On average, about how much more per month are you spending now on food and nonalcoholic beverages than you were in the month before your last interview?

$ ☐☐☐

B. What are the main reasons you are spending more now than before your last interview? RECORD VERBATIM.

_____
_____ (E-12.)
_____

C. On average, about how much less per month are you spending now on food and nonalcoholic beverages than before your last interview?

$ ☐☐☐

D. What are the main reasons you are spending less now than before your last interview? RECORD VERBATIM.

_____
_____

E-12. Now I would like to talk to you about assistance you (or any members of your family unit) may have received from various food programs during the past month. First, during the past month, have you (or any members of your family unit) received any Federal Food Stamps?

Yes 01
No. 02 (E-13.)

A. What was the value of all food stamps received last month?

$ ☐☐☐

E-13. During the past month, have you (or any members of your family unit) received any benefits or services from the WIC Program--the Special Food Program for Women, Infants, and Children?

Yes 01
No. . . . . 02 (CHECKPOINT C.)

A. During the past month, how many women in your family unit, including yourself, received benefits or services from the WIC Program? IF NONE, ENTER 00.

☐☐ Women

IF RESPONDENT IS ONLY FAMILY UNIT MEMBER, GO TO CHECKPOINT C.

B. (IF ANY IN FAMILY UNIT): And how many infants 3 months old or younger received such benefits or services? IF NONE, ENTER 00.

☐☐ Infants (3 mos. or younger)

C. (IF ANY IN FAMILY UNIT): How many infants 4 months to 1 year old (received such benefits or services)? IF NONE, ENTER 00.

☐☐ Infants (4 mos. to 1 year)

D. (IF ANY IN FAMILY UNIT): How many children between 1 and 5 years old (received such benefits or services)? IF NONE, ENTER 00.

☐☐ Children (1 to 5 years)

CHECKPOINT C

ARE ANY FAMILY UNIT MEMBERS 18 YEARS OLD OR YOUNGER?

☐ YES → Q. E-14.

☐ NO → Q. E-17.

E-14. During the past month, have (you or) any children in your family unit purchased, or received free, any meals at school, or in a day-care, Head Start, kindergarten, or other preschool program?

Yes. 01
No 02 (E-15.)

A. What are the first names of the children who purchased, or received free, meals at school or in a preschool program? ENTER THE NAME OF EACH CHILD PURCHASING OR RECEIVING MEALS AT SCHOOL IN COLUMN 1 OF TABLE AND CIRCLE "C" IN COLUMN 2 FOR EACH NAME ENTERED.

E-15. ASK ONLY IF ALL PEOPLE 18 OR UNDER ARE NOT LISTED IN TABLE. During the school year, do (you or) any (other) children in your family unit usually purchase, or receive free, any meals at school, or in a daycare, Head Start, kindergarten, or other preschool program?

Yes. 01
No . . . . . 02 (CHECKPOINT D.)

A. What are the first names of the children who usually purchase, or receive free, meals at school or in a preschool program? ENTER THE NAME OF EACH CHILD PURCHASING OR RECEIVING MEALS AT SCHOOL IN COLUMN 1 OF TABLE AND CIRCLE "U" IN COLUMN 2 FOR EACH NAME ENTERED.

CHECKPOINT D

ARE ANY NAMES LISTED IN TABLE?

☐ YES → Q. E-16.

☐ NO → Q. E-17.

E-16. ASK Qs. A-C FOR EACH CHILD LISTED IN TABLE.

A. On average, about how many meals per week did (NAME) (usually) purchase or receive at school or preschool (during the past month)? ENTER NUMBER OF MEALS IN COLUMN 3 BESIDE NAME.

B. What was the usual weekly expense for the meals (NAME) purchased or received at school or preschool? ENTER AMOUNT IN COLUMN 4 BESIDE NAME. IF MEALS ARE FREE, ENTER 00.

C. And where did (NAME) usually eat the meals--at (elementary or high) school or in preschool program? CIRCLE NUMBER CORRESPONDING TO TYPE OF SCHOOL IN COLUMN 5 BESIDE NAME.

1	2	3	4	5
NAME OF CHILD	CURRENTLY OR USUALLY RECEIVE?	AVERAGE NO. OF MEALS PER WEEK	USUAL WEEKLY EXPENSE	TYPE OF SCHOOL: 1 = GRADE OR HIGH SCHOOL 2 = PRESCHOOL
	C U	☐☐	$ ☐☐	1 2
	C U	☐☐	$ ☐☐	1 2
	C U	☐☐	$ ☐☐	1 2
	C U	☐☐	$ ☐☐	1 2
	C U	☐☐	$ ☐☐	1 2
	C U	☐☐	$ ☐☐	1 2
	C U	☐☐	$ ☐☐	1 2
	C U	☐☐	$ ☐☐	1 2

E-17. Finally, during the past month, have you (or any members of your family unit) received any free food, beverages, or meals through public or private welfare agencies, including religious organizations? (DO NOT INCLUDE FREE MEALS IN SCHOOL OR PRESCHOOL PROGRAMS.)

Yes. 01
No . . . . . 02 (RECORD END TIME.)

A. About how much would that food have cost if you had bought it?

$ ☐☐☐

Don't know. . . . DK

End Time _____ am
pm

CONTINUE WITH MEASUREMENTS.

WOMEN'S MEASUREMENT FORM

NAME (FIRST, MIDDLE, LAST)	DATE OF MEASUREMENTS ☐☐ Month ☐☐ Day ☐☐ Year

1. TYPE OF CLOTHING DURING WEIGHT
   - Gown and slippers 01
   - Light street clothing . . . 02
   - Other (SPECIFY) 03

   _____

2. WEIGHT ☐☐☐ · ☐☐ lb. OR ☐☐☐ · ☐☐ kg.

3. LEFT ARM CIRCUMFERENCE ☐☐ · ☐ cm.

4. LEFT TRICEPS SKINFOLD

   IF MEASURES DIFFER BY MORE THAN 3 mm., TAKE THIRD MEASURE.

   (a) ☐☐ · ☐ mm.
   (b) ☐☐ · ☐ mm.
   (c) ☐☐ · ☐ mm.

5. LEFT SUBSCAPULAR SKINFOLD

   IF MEASURES DIFFER BY MORE THAN 3 mm., TAKE THIRD MEASURE.

   (a) ☐☐ · ☐ mm.
   (b) ☐☐ · ☐ mm.
   (c) ☐☐ · ☐ mm.

6. COMMENTS ON MEASUREMENTS: _____

   _____

   _____

7. WEIGHT WAS...
   - Abstracted from record 01
   - Taken by operative 02

8. ESTIMATE THE TOTAL NUMBER OF MINUTES REQUIRED TO TAKE MEASUREMENTS AND ABSTRACT DATA.

   ☐☐ Minutes

OMB No. 0584-0306
Expires 12/31/83

SPECIAL FOLLOW-UP SUPPLEMENT

A Study of
Health and Nutrition of Mothers and Their Children

Sponsored by

Food and Nutrition Service
U.S. Department of Agriculture

Conducted by

New York State Research Foundation
and
Research Triangle Institute

PUT "P" LABEL
FROM ACF HERE.

INSTRUCTIONS

RECORD DURATION OF GESTATION FROM Q. 2 ON SCREENING FORM: ☐☐ Weeks OR ☐☐ Months

- IF NUMBER OF WEEKS IS 32 OR MORE, COMPLETE SUPPLEMENT.
- IF NUMBER OF MONTHS IS 8 OR MORE, COMPLETE SUPPLEMENT.

A. CURRENT PREGNANCY

A-2. Where have you usually gone to get medical care during this pregnancy?

(CIRCLE ONE.)

Doctor's office (group practice or doctor's clinic). 01
Hospital outpatient clinic 02
Health Center. 03
Hospital emergency room. 04
Company/industry clinic. 05
Patient's home 06
Other. 07
Don't know . . . . . DK

A-3. Would you say that it has been very difficult, fairly difficult, or not difficult at all...

		VERY DIFFICULT	FAIRLY DIFFICULT	NOT DIFFICULT AT ALL	NOT APPLICABLE
A.	Getting an appointment to see a doctor or other medical person at (PLACE)?	01	02	03	NA
B.	Arranging to get to (PLACE) when it is open?	01	02	03	NA
C.	Getting to and from (PLACE)?	01	02	03	NA
D.	Having your children taken care of so that you can get your medical care?	01	02	03	NA
E.	Paying for transportation costs to and from (PLACE)?	01	02	03	NA
F.	Paying for prenatal care you get at (PLACE)?	01	02	03	NA

A-4. Are you now covered by...

	YES	NO	DON'T KNOW
A. Medicaid (which is also called (STATE NAME FOR MEDICAID)?	01	02	DK
B. Private health insurance, such as Blue Cross/Blue Shield, or some other plan?	01	02	DK
C. Membership in a health maintenance organization (HMO) or prepaid health plan (PHP)?	01	02	DK
D. Any other type of health insurance plan or program?	01	02	DK

A-5. Do you receive any medical care at a reduced cost from a clinic or hospital?

Yes 01
No 02
Don't know . . . . . DK

A-9. People sometimes eat things that are usually not considered food. During this pregnancy, have you eaten starch, soap, dirt, clay, or anything else that is usually not considered food?

Yes 01
No 02 (A-10.)

A. What kinds of things?
(CIRCLE ALL THAT APPLY.)

Clay 01
Dirt 02
Soap 03
Starch 05
Other (SPECIFY) 06

_____

A-10. Have you had any illnesses or complications during this pregnancy?

Yes 01
No 02 (A-11.)

A. What kinds of illnesses or complications? RECORD VERBATIM.

(1) _____
(2) _____
(3) _____
(4) _____
(5) _____

A-11. Have you had any vomiting during this pregnancy?

Yes 01
No 02 (A-12.)

A. About how many days altogether have you had vomiting?

☐☐☐ Days

A-12. Have you had severe nausea during this pregnancy--that is, have you felt sick without vomiting?

Yes 01
No 02 (A-14.)

A. About how many days altogether have you had severe nausea?

☐☐☐ Days

A-14. Have you decided how you will feed your baby?

Yes 01
No . . . . . 02 (SECTION B.)

A. How do you plan to feed your baby?

Breastfeeding 01
Bottle and formula 02
Combination 03
Other (SPECIFY) 04

_____

B. What are your reasons for choosing this method? RECORD VERBATIM.

_____

_____

_____

B. HOUSING CHARACTERISTICS

B-1. How many rooms do you have in your living quarters, not counting bathrooms, porches, balconies, foyers, halls, or half rooms?

☐☐ Rooms

B-2. Do you have complete kitchen facilities in your living quarters, including a sink with piped water, a range or cookstove, and a refrigerator?

Yes 01
No 02 (B-3.)

A. Do you share these kitchen facilities with members of another household?

Yes 01
No. 02

B-3. Do you have complete plumbing facilities in your living quarters--that is, hot and cold piped water, a flush toilet, and a bathtub or shower?

Yes. 01
No 02 (B-4.)

A. Do you share these plumbing facilities with members of another household?

Yes 01
No. 02

B-4. Do you (or a member of your household) own your living quarters, do you rent your living quarters, or do you live there without paying any rent?

Own. 01
Rent for cash. 02
Occupy without paying rent 03

OMB No. 0584-0306
Expires 12/31/83

NUTRITION EDUCATION QUESTIONNAIRE

A Study of
Health and Nutrition of Mothers and Their Children

Sponsored by

Food and Nutrition Service
U.S. Department of Agriculture

Conducted by

New York State Research Foundation
and
Research Triangle Institute

ID LABEL

NOTICE: This study has been authorized by the U.S. Congress in its 1978 reauthorization of the WIC Program (Public Law 95-627). All information that would permit identification of an individual, facility, or state or local agency will be held in strict confidence, will be used only by persons engaged in and for the purposes of the survey, and will not be disclosed or released to others for any purposes.

1. What percentage of your pregnant women clients receive nutrition education or advice?

_____% of pregnant clients

A. How many times, on the average, do your pregnant clients receive nutrition education or advice?

_____ Times

2. In Column A below, please circle the code for "YES" or "NO" to indicate which, if any, oral presentation methods are used for nutrition education for pregnant women. In Column B, please circle the code beside the one method that is used most often.

		A		B
		METHOD USED?		USED MOST OFTEN
		YES	NO	
(1)	One-to-one counseling.	01	02	01
(2)	Group discussion/seminars/classes. . . .	01	02	02

A. In Column A, please circle the code for "YES" or "NO" to indicate which, if any, written or visual materials are used for nutrition education for pregnant women. In Column B, circle the code beside the one method that is used most often.

		A		B
		METHOD USED?		USED MOST OFTEN
		YES	NO	
(1)	Audiovisual presentations (films, slides).	01	02	01
(2)	Written materials (pamphlets).	01	02	02
(3)	Other (PLEASE DESCRIBE).	01	02	03

_____

_____

3. Do you have written nutrition education plans, guidelines, or instructions for use with...

		(CIRCLE ONE NUMBER ON EACH LINE.)	
		YES	NO
A.	Pregnant women?	01	02
B.	Breastfeeding women?.	01	02
C.	Postpartum (not breastfeeding) women?	01	02
D.	Infants and children under 5 years?	01	02

4. A number of topics that may be included in nutrition education are listed below. For each topic listed, please circle the code that best describes the level of emphasis placed on the topic in your nutrition education program and materials.

		(CIRCLE ONE NUMBER ON EACH LINE.) NOT INCLUDED	LITTLE EMPHASIS	SOME EMPHASIS	MUCH EMPHASIS
A.	General nutrition and nutrients	01	02	03	04
B.	Nutritional requirements during pregnancy	01	02	03	04
C.	Special diets for complications of pregnancy, such as diabetes, hypertension, anemia, etc.	01	02	03	04
D.	Postpartum nutrition and weight control	01	02	03	04
E.	Nutritional requirements during infancy	01	02	03	04
F.	Infant feeding practices and weaning	01	02	03	04
G.	Nutritional requirements during childhood and child feeding practices	01	02	03	04
H.	Pica	01	02	03	04
I.	Smoking during pregnancy	01	02	03	04
J.	Alcohol consumption during pregnancy	01	02	03	04
K.	Substance abuse (such as marijuana, cocaine, sedatives, etc.)	01	02	03	04
L.	Breastfeeding	01	02	03	04
M.	Importance of regular health care	01	02	03	04
N.	Food purchasing, preparation, and storage (including shopping hints, recipes, budget advice, etc.)	01	02	03	04
O.	Other topics (PLEASE DESCRIBE)	01	02	03	04

_____

_____

5. Do you (and your staff or other facility staff) provide information or advice on infant feeding methods?

(CIRCLE ONE.)

Yes 01
No. . . . . 02 (GO TO QUESTION 6.)

A. On which infant feeding method(s) is information provided?

(CIRCLE ONE.)

Breastfeeding. 01
Bottle and formula . . 02
Both 03

B. What infant feeding method is most often recommended by your staff?

(CIRCLE ONE.)

Breastfeeding. 01
Bottle and formula . . 02
Combined feeding (breast and bottle). 03
Depends on individual circumstances. . . . 04

6. In the table below, please provide the following information about the availability of written materials and oral presentations on nutrition education in languages other than English.

- In Column A, please circle the code for "YES" or "NO" to indicate if written and audiovisual materials (if used) are available in the languages listed.

- In Column B, please circle the code for "YES" or "NO" to indicate if staff presentations on nutrition education or advice are made in the languages listed.

		A		B	
		WRITTEN OR AUDIOVISUAL MATERIALS		STAFF ORAL PRESENTATIONS	
	LANGUAGE	YES	NO	YES	NO
(1)	Chinese	01	02	01	02
(2)	French	01	02	01	02
(3)	German	01	02	01	02
(4)	Italian	01	02	01	02
(5)	Portugese	01	02	01	02
(6)	Spanish	01	02	01	02
(7)	Vietnamese	01	02	01	02
(8)	Other (PLEASE DESCRIBE) _____	01	02	01	02
	_____				

7. What is the total number of staff members who provide nutrition education or advice?

_____ number of staff

8. Please enter the number of each category of staff listed below who provide nutrition education or advice.

STAFF CATEGORY	NUMBER
(1) Nutritionist	
(2) Nutrition aide	
(3) Nutrition trainee	
(4) Dietitian	
(5) Home economist	
(6) Primary provider (M.D., P.A., F.N.P., etc.)	
(7) Volunteer worker	
(8) Other (PLEASE DESCRIBE)	
_____	

9. Are there any factors--such as space, lack of staff, budget constraints, or time with clients--that limit your ability to provide nutrition education or advice to clients?

(CIRCLE ONE.)

Yes 01
No. . . . . 02 (GO TO QUESTION 10.)

A. What are these limiting factors?

(CIRCLE ALL THAT APPLY.)

Space in facility 01
Lack of staff 02
Budget constraints. 03
Available time with clients 04
Lack of program materials 05
Low priority given nutrition education. 06
Other (PLEASE DESCRIBE) 07

_____

10. Please provide the following information about yourself.

NAME _____

TITLE _____

ACADEMIC DEGREE(S) _____

PROFESSIONAL CERTIFICATION(S) _____

_____

PLEASE ATTACH A COPY OF ALL NUTRITION EDUCATION MATERIALS THAT ARE AVAILABLE FOR DISTRIBUTION TO PREGNANT WOMEN.

PLEASE ATTACH A COPY OF ALL WRITTEN PLANS, GUIDELINES, OR INSTRUCTIONS FOR NUTRITION EDUCATION FOR PREGNANT WOMEN. INCLUDE ANY OUTLINES OR GUIDES USED BY STAFF IN ONE-TO-ONE AND GROUP DISCUSSIONS.

(CHECK ONE.)

MATERIALS ATTACHED ☐

MATERIALS NOT AVAILABLE ☐

PLEASE RETURN THIS QUESTIONNAIRE TO YOUR ADMINISTRATOR WHEN YOU HAVE COMPLETED IT.

THANK YOU.

WIC VOUCHER/FOOD PACKAGE ISSUANCE DATA FORM FORM ___ OF ___

A Study of Health and Nutrition of Mothers and Their Children

A. VOUCHER ISSUANCE DATA

1. Is the sample woman's address on clinic records the same as the address listed on the label?

   Yes . . 01

   No. . . 02 → ENTER TELEPHONE NUMBER AND COMPLETE ADDRESS:

   (_____) _____ - _____

   _____

   _____

   _____

2. What was the WIC Priority Code that was assigned to this woman?

   ☐☐

3. What was the reason this woman was certified to receive WIC benefits/services? (CIRCLE ALL THAT APPLY.)

   Anemia 01
   Inadequate Growth 02
   Inadequate Dietary Status 03
   High Risk Pregnancy 04
   Other (SPECIFY) 05

   _____

   _____

   _____

   Reason Not Stated in Records 06

4. What is this sample clinic's voucher/food package issuance cycle?

   On Certification Date and Once A Week Thereafter 01
   On Certification Date and Every Two Weeks Thereafter . . . 02
   On Certification Date and Monthly Thereafter 03
   On Certification Date and Every Two Months Thereafter . . 04
   Other (SPECIFY) 05

   _____

B. IDENTIFICATION

AFFIX LABEL HERE

FO Name _____ ID # _____

5. Are foods prescribed for this sample woman described on clinic records by food package codes?

   Yes . . 01 → COMPLETE ALL APPLICABLE PARTS ON THE REVERSE SIDE OF THIS FORM. OBTAIN THREE COPIES OF FOOD MATRIX/TABLE AND RETURN TO RTI WITH ALL COMPLETED FORMS FOR THIS CLINIC.

   No. . . 02 → COMPLETE ALL APPLICABLE PARTS ON THE REVERSE SIDE OF THIS FORM AND A FOOD PACKAGE CONTENT SECTION FOR EACH FOOD PACKAGE ISSUED.

a	b	c	d					e		f
Visit	Date	Number of Food Instruments Issued	Serial Numbers of Food Instruments Issued					Was the food package prescribed a standard package or was it tailored according to the woman's needs? Standard*	Tailored**	Food Package Code ***
Certification Visit 1								01	02	
Visit 2								01	02	
Visit 3								01	02	
Visit 4								01	02	
Visit 5								01	02	
Visit 6								01	02	
Visit 7								01	02	
Visit 8								01	02	
Visit 9								01	02	
Visit 10								01	02	
Visit 11								01	02	
Visit 12								01	02	

*ENTER FOOD PACKAGE CODE IN COLUMN f IF APPLICABLE.

**COMPLETE A FOOD PACKAGE CONTENT SECTION FOR EACH FOOD PACKAGE THAT WAS TAILORED.

***IF THE CLINIC DOES NOT USE FOOD PACKAGE CODES, COMPLETE A FOOD PACKAGE CONTENT SECTION FOR EACH FOOD PACKAGE ISSUED.

FORM ___ OF ___

FOOD PACKAGE CONTENT SECTION

A Study of Health and Nutrition of Mothers and Their Children

A. IDENTIFICATION

WID [ ][ ][ ][ ][ ][ ][ ] Woman's Name _____

B. FOOD PACKAGE CONTENT

LIST THE TYPES OF FOODS AND THE QUANTITIES PRESCRIBED ON EACH VISIT.

Visit Number _____ Date ____/____/____

Food Item	Purchase Unit /Size	Maximum Quantity

Visit Number _____ Date ____/____/____

Food Item	Purchase Unit /Size	Maximum Quantity

(CONTINUE ON REVERSE SIDE)

Visit Number ____________ Date ____/____/____

Food Item	Purchase Unit /Size	Maximum Quantity

Visit Number ____________ Date ____/____/____

Food Item	Purchase Unit /Size	Maximum Quantity

Visit Number ____________ Date ____/____/____

Food Item	Purchase Unit /Size	Maximum Quantity

Visit Number ____________ Date ____/____/____

Food Item	Purchase Unit /Size	Maximum Quantity

HOSPITAL RECORDS ABSTRACT FORM
A Study of Health and Nutrition
of Mothers and Their Children

OMB No. 0584-0306
Expires 3/31/84

A. IDENTIFICATION

1. Mother's ID No. [ID LABEL]

Mother's Name (First, Middle, Last)		
Street Address		
City	State	ZIP
MOTHER'S DATE OF BIRTH (Month / Day / Year)	HOSPITAL IDENTIFICATION: PSU [ ][ ][ ][ ][ ][ ][ ] Sequence [ ][ ][ ][ ] - [ ]	

B. PRENATAL RECORD

(IF PATIENT'S PRENATAL RECORD IS NOT AVAILABLE AT YOUR FACILITY, PLEASE CHECK THIS BOX ☐ AND GO TO SECTION C. ON PAGE 2.)

1. Number of Prenatal Visits [ ][ ] ☐ 94 Unknown/Not Stated

2. a. Date of Last Prenatal Visit: [ ][ ] Month [ ][ ] Day [ ][ ] Year

b. Weight at Last Visit: [ ][ ][ ] lbs.

3. Highest Blood Pressure: [ ][ ][ ] Systolic [ ][ ][ ] Diastolic

4. a. Earliest Recorded Hemoglobin Value: [ ][ ] . [ ] gms. per dl.

b. Date of Earliest Hemoglobin Value: [ ][ ] Month [ ][ ] Day [ ][ ] Year

c. Latest Recorded Hemoglobin Value: [ ][ ] . [ ] gms. per dl.

d. Date of Latest Hemoglobin Value: [ ][ ] Month [ ][ ] Day [ ][ ] Year

5. a. Earliest Recorded Hematocrit Value: ☐☐ %

b. Date of Earliest Hematocrit Value: ☐☐ Month ☐☐ Day ☐☐ Year

c. Latest Recorded Hematocrit Value: ☐☐ %

d. Date of Latest Hematocrit Value: ☐☐ Month ☐☐ Day ☐☐ Year

6. Was any indication of substance use or abuse noted in the record?

☐ 01 Yes ☐ 02 No

If yes, please describe _____

_____

7. Were any abnormalities of pregnancy (e.g., toxemia, diabetes or abnormal glucose tolerance, etc.) noted in the record?

☐ 01 Yes ☐ 02 No

If yes, please describe _____

_____

_____

C. DELIVERY RECORD

		Month	Day	Year
1. Dates of	a. Hospital Admission	☐☐	☐☐	☐☐
	b. Delivery	☐☐	☐☐	☐☐
	c. Mother's Discharge	☐☐	☐☐	☐☐
	d. Infant's Discharge	☐☐	☐☐	☐☐

2. Labor: ☐ 01 Induced ☐ 02 Spontaneous ☐ 94 Unknown/Not Stated

3. Type of Delivery: ☐ 01 Vaginal ☐ 02 Caesarean ☐ 94 Not Stated

4. Multiple Birth: ☐ 01 Yes ☐ 02 No (If yes, complete Part D below for each infant/fetus.)

5. Placental Weight: ☐☐☐ gms. ☐ 94 Not available

6. Were any abnormalities of labor and/or delivery noted in the record?

☐ 01 Yes ☐ 02 No

If yes, please describe _____

_____

_____

D. INFANT RECORD

1. Vital Status: ☐ 10 Alive

☐ 20 Stillborn
- ☐ 21 Antepartum (Before Birth) Fetal Death*
- ☐ 22 Intrapartum (During Birth) Fetal Death*
- ☐ 94 Unknown*

☐ 30 Liveborn, Died in Infancy* → Age at Death (Days) ☐☐

*Indicate cause(s) of death (If Known) _____ _____ _____ ICD CODE ☐☐☐☐☐☐ ☐☐☐☐☐☐ ☐☐☐☐☐☐

2. Sex: ☐ 01 Male ☐ 02 Female ☐ 94 Unknown

3. Birthweight: ☐☐☐☐ gms. or ☐☐ lbs. ☐☐ . ☐ oz.

☐ 94 Not available

DATE MEASURED Month Day Year

4. Birth Length: ☐☐ . ☐ cm. or ☐☐ . ☐☐ in. ☐☐ ☐☐ ☐☐

☐ 94 Not available

5. Head Circumference: ☐☐ . ☐ cm. or ☐☐ . ☐☐ in. ☐☐ ☐☐ ☐☐

☐ 94 Not available

6. Transfer to Special Care

(1) Internal: ☐ 01 Yes ☐ 02 No ☐ 94 Not Stated

If yes, age (days) ☐☐ and reason _____

_____

(2) Other Institution: ☐ 01 Yes ☐ 02 No ☐ 94 Not Stated

If yes, age (days) ☐☐ and reason _____

_____

If yes, please enter the name of the other institution _____

_____

7. Were any neonatal illnesses, congenital anomalies, or problems not mentioned above noted in the record?

☐ 01 Yes ☐ 02 No

If yes, please describe ICD Code

_____ ☐☐☐☐.☐☐

_____ ☐☐☐☐.☐☐

8. Feeding:

	Primary Method	Any Use	No Mention
a. Breast	☐ 01	☐ 02	☐ 03
b. Formula, bottle	☐ 01	☐ 02	☐ 03
c. Formula, gavage	☐ 01	☐ 02	☐ 03
d. Intravenous	☐ 01	☐ 02	☐ 03

9. Was free formula given to patient at or before discharge?

☐ 01 Yes ☐ 02 No ☐ 94 Not Stated

Completed By

_____
Name

Date Completed
Month ☐☐ Day ☐☐ Year ☐☐

FOR RTI OPERATIVE USE ONLY.

RTI ID # _____

HOSPITAL RECORDS ABSTRACT FORM
MULTIPLE BIRTHS
INFANT RECORD CONTINUATION FORM
A Study of Health and Nutrition
of Mothers and Their Children

OMB No. 0584-0306
Expires 03/31/84

A. IDENTIFICATION

1. Mother's ID No. [| | | | | | |]

Mother's Name (First, Middle, Last)		
Street Address		
City	State	ZIP
MOTHER'S DATE OF BIRTH [ ][ ] Month [ ][ ] Day [ ][ ] Year	HOSPITAL IDENTIFICATION PSU [							] Sequence [				] - [ ]	

D. INFANT RECORD

(Complete one of these forms for each additional infant/fetus.)

1. Vital Status:
- [ ] 10 Alive
- [ ] 21 Antepartum (Before Birth) Fetal Death*
- [ ] 20 Stillborn
- [ ] 22 Intrapartum (During Birth) Fetal Death*
- [ ] 94 Unknown*
- [ ] 30 Liveborn, Died in Infancy* → Age at Death (Days) [ ][ ]

*Indicate cause(s) of death (If Known) _____ _____ _____ ICD CODE [| | | | | |] [| | | | | |] [| | | | | |]

2. Sex: [ ] 01 Male [ ] 02 Female [ ] 94 Unknown

3. Birthweight: ☐☐☐ gms. or ☐☐ lbs. ☐☐ . ☐ oz.

☐ 94 Not available

DATE MEASURED
Month Day Year

4. Birth Length: ☐☐ . ☐ cm. or ☐☐ . ☐☐ in. ☐☐ ☐☐ ☐☐

☐ 94 Not available

5. Head Circumference: ☐☐ . ☐ cm. or ☐☐ . ☐☐ in. ☐☐ ☐☐ ☐☐

☐ 94 Not available

6. Transfer to Special Care

(1) Internal: ☐ 01 Yes ☐ 02 No ☐ 94 Not Stated

If yes, age (days) ☐☐ and reason _____

_____

(2) Other Institution: ☐ 01 Yes ☐ 02 No ☐ 94 Not Stated

If yes, age (days) ☐☐ and reason _____

_____

If yes, please enter the name of the other institution _____

_____

7. Were any neonatal illnesses, congenital anomalies, or problems not mentioned above noted in the record?

☐ 01 Yes ☐ 02 No

If yes, please describe ICD Code

_____ ☐☐☐☐☐☐

_____ ☐☐☐☐☐☐

8. Feeding:

		Primary Method	Any Use	No Mention
a.	Breast	☐ 01	☐ 02	☐ 03
b.	Formula, bottle	☐ 01	☐ 02	☐ 03
c.	Formula, gavage	☐ 01	☐ 02	☐ 03
d.	Intravenous	☐ 01	☐ 02	☐ 03

9. Was free formula given to patient at or before discharge?

☐ 01 Yes ☐ 02 No ☐ 94 Not Stated

Completed By

_____
Name

Date Completed
Month ☐☐ Day ☐☐ Year ☐☐

FOR RTI OPERATIVE USE ONLY.

RTI ID # _____

HOSPITAL INFANT MEASUREMENTS PROTOCOL QUESTIONNAIRE

A STUDY OF HEALTH AND NUTRITION OF MOTHERS AND THEIR CHILDREN

IDENTIFICATION

PSU | | | | | | | | Sequence No. | | | | | |

Hospital Name: _____

Address: _____

_____

Phone: ( ) -

1. What type of scale does your facility use to weigh newborns? (CIRCLE APPROPRIATE CODE)

   Spring scale. 01
   Beam Balance Scale. 02
   Digital scale 03
   Other (PLEASE SPECIFY). 04

   _____

   _____

2. Where are newborns usually weighed?

   In the delivery room. . . . . 01 (GO TO Q. 3.)
   In the newborn nursery. . . . . 02 (GO TO Q. 2.A.)

   A. Is the newborn weighed immediately upon arrival in the newborn nursery or later?

      Immediately upon arrival 01
      Later. 02

3. Are newborns <u>usually</u> weighed...

   with light clothing (T-shirt and diaper)? 01
   in diapers only? 02
   nude? 03

4. When and how often is the zero reading of the scale used to weigh newborns checked?

   At each weighing. 01
   At each shift 02
   Daily 03
   Other (PLEASE SPECIFY). 04

   _____

   _____

5. Is the placenta usually weighed?

Yes . . . . . 01 (GO TO Q. 5.A.)
No. . . . . 02 (GO TO Q. 6.)

A. Is the placenta trimmed before it is weighed?

Yes. 01
No 02

6. Is the newborn's length routinely measured?

Yes . . . . . 01 (GO TO Q. 6.A.)
No. . . . . 02 (GO TO Q. 7.)

A. Is a measuring board or a tape used to measure the newborn's length?

Measuring board. . . . . 01 (GO TO Q. 7.)
Tape . . . . . 02 (GO TO Q. 6.B.)

B. What type of tape does your facility use to measure the newborn's length?

Cloth or vinyl tape. 01
Paper tape 02
Both 03

7. Is the newborn's head circumference usually measured?

Yes . . . . . 01 (GO TO Q. 7.A.)
No. . . . . 02 (GO TO Q. 8.)

A. What type of tape does your facility use to measure the newborn's head circumference?

Cloth or vinyl tape. 01
Slotted paper tape 02
Paper tape, not slotted 03

8. Please enter your name and phone number below.

Name: _____

Phone: ( ) _____

THANK YOU FOR COMPLETING THIS FORM. PLEASE ENCLOSE IT IN THE ATTACHED PRE-ADDRESSED, POSTAGE-PAID ENVELOPE AND DROP IT IN THE MAIL.

ASSIGNMENT CONTRDL FDRM
RTI PRDJECT 2447

CATI ID 50101 PSU 3189721 CLINIC TYPE WIC FS NAME SMITH

CLINIC ID _____ DPERATIVE _____ ID# _____

SCREENING FORM

1000203
NAME _____
ADDRESS _____
CITY _____

FOLLOW UP INTERVIEW DATA SHEET

1000203 50101
NAME _____
ADDRESS _____
CITY _____

CONSENT FORM AUTHORIZATION FORM HRAF DIARY DIARY Q

1000203 1000203 1000203 1000203 1000203

SAMPLE CHILD PACKAGE

1000216 1000229 1000232 1000245 1000258

**123546

1000261 1000274 1000287 1000290

INITIAL INTERVIEW

1000203 0
NAME _____
ADDRESS _____
CITY _____

FOLLOW-UP INTERVIEW PACKAGE

1000203 0
NAME _____
ADDRESS _____
CITY _____

1000203 1000203 1000203
NAME _____ NAME _____ NAME _____
DATE _____ T_____ DATE _____ T_____ DATE _____ T_____

1000203 1000203 1000203
NAME _____ NAME _____ NAME _____
DATE _____ T_____ DATE _____ T_____ DATE _____ T_____

SAMPLING MESSAGE:
NO DIETARY INTERVIEW

INITIAL INTERVIEW STATUS

1. SCREENING DATE _____
2 INTERVIEW DATE _____
3 MAIL DATE TO RTI _____
4 WAS A SAMPLE CHILD SELECTED?

☐ YES → DATE ALL CHILDREN'S DATA CDLLECTIDN CDMPLETED _____

MAIL DATE TD RTI _____

☐ NO → 6

5 WERE DATA CDLLECTED DN CHILDREN DTHER THAN THE SAMPLE CHILD?

☐ YES → HDW MANY DTHERS _____
☐ ND → 6

6 FDR BLDDD SAMPLE PSUS DNLY: WAS A BLDDD SAMPLE TAKEN DN DAY OF WDMAN'S INITIAL VISIT?

☐ YES
☐ ND

FOLLOW-UP INTERVIEW STATUS

1 INTERVIEW PERIDD _____ - _____
2 INTERVIEW DATE _____
3 IS WDMAN IN DIARY SAMPLE?

☐ YES → PICK-UP DATE _____

MAIL DATE TO RTI _____

☐ ND → 4

4 IS BLDDD SAMPLE REQUIRED?

☐ YES
☐ ND

STATUS CDDES ASSIGNED

WDMAN		DATE ASSIGNED	CHILDREN	
PENDING	FINAL		PENDING	FINAL

NDTES _____

Please rate this site relative to all others with which you are familiar. Circle one number from 1 to 5 for each statement, indicating a rating of:

(1) much worse than average
(2) worse than average
(3) average
(4) better than average
(5) much better than average

	much worse than average	worse than average	average	better than average	much better than average
1) Amount of counselling provided.	1	2	3	4	5
2) Quality of nutrition education.	1	2	3	4	5
3) Quality of individual care plans.	1	2	3	4	5
4) Efficiency of voucher and/or food package distribution.	1	2	3	4	5
5) Integration with health care system.	1	2	3	4	5
6) Overall staff excellence/ qualifications.	1	2	3	4	5
7) Staff motivation and morale.	1	2	3	4	5
8) Overall compliance with federal regulations and state policies and procedures.	1	2	3	4	5
9) Outreach to the community.	1	2	3	4	5
10) Overall rating of this WIC site.	1	2	3	4	5

Clinic Administrator and Nutrition Education Questionnaire Appendices

A scoring system was created and applied to the Nutrition Education and Clinic and WIC Site Administrator Questionnaires (see Exhibit A) from all clinics, both WIC sites and prenatal clinics in which control women were recruited. The aim was to rank clinics according to the quantity and quality of services offered. Many questions were not scored, since they identified characteristics of the clinics that were descriptive, and not evaluative.

The scores for the questions were summed for each clinic. Since there were some non-comparable questions on the administrator questionnaires (the same Nutrition Education Questionnaire was used for both types of clinic) the scores for the two sets of questionnaires were standardized separately. The scores were positively correlated with the state WIC managers' ranking (0.18, $p=0.06$). However, the scores did not relate significantly to any study outcome, and these analyses have therefore been omitted from the report. A next and more sophisticated analytic approach would be to apply factor analyses to the responses, and relate the separate factor scores to outcome. Lack of time precluded pursuing this approach.

Exhibit A: Nutrition Education Questionnaire

Question	Response	Scoring System Points
1. What percentage of your pregnant women clients receive nutrition education or advice?	≥90%	5
	70-89%	3
	25-69%	0
	<25% or no response	-1
1.A. How many times, on the average, do your pregnant clients receive nutrition education or advice?	>3	3
	2-3	2
	1	1
	<1 or no response	-1
2. Oral presentation methods used?	>1 method used	1
	1 method used	1
	No methods used or no response	0
2A. Written or visual materials used?	>1 method used	2
	1 method used	1
	No methods used or no response	0
3A. Any written nutrition education plans, guidelines, or instructions for use with pregnant women?	Yes	1
	No or no response	0
4A-4N. Level of emphasis placed on topic in your nutrition education program?	Number of items scored as "some emphasis" or "much emphasis"	
	= 10-14	3
	= 6-9	2
	= 3-5	1
	= <3 or no response	0
4O-4Q. Level of emphasis placed on topic in your nutrition education program?	Number of items scored as "some emphasis" or "much emphasis"	
	= ≥1	1
	= <1	0
5A. On which infant feeding method(s) is information provided?	Information provided on:	
	Breastfeeding or both breast and bottle feeding	3
	Bottle and formula	1
	Not provided (from Question	

	#5: _____)	0
5B. What infant feeding method is most often recommended by your staff?	Feeding method recommended:	
	Breastfeeding or depends on circumstances	3
	Combined feeding (breast and bottle)	2
	Bottle and formula	1
8. Number and type of staff who provide nutrition education or advice?	Nutritionist or Dietitian ≥1	5
	Nutrition trainee, home economist, primary provider or other health educator ≥1	3
	Nutrition aide, social service worker ≥1	2
	Volunteer or other worker ≥1	0
	No response or 0 for all categories	-1
9A. Factors limiting ability to provide nutrition education or advice to clients...	If ≥3 limiting factors	-3
	If 2 limiting factors	-2
	If 1 limiting factor	-1
	If no limiting factors or no response	
Written materials attached?	Materials attached	
	Materials not attached	

Exhibit B: WIC Site Administrator's Questionnaire

Question	Scoring System Response	Points
4B. For pregnant women who... have to wait to be deemed eligible to receive WIC services..., what is the average waiting time, in weeks, from date of application to the time of WIC certification?	If waiting time:	
	< one week	0
	≥ one week	-2
6. (Column B, other hours) All times each day that the site is open for services to pregnant clients.	If hours open include:	
	Any weekend hours or hours other than 9 to 5	1
	Only weekday 9 to 5 hours	0
7C. At what interval are food vouchers dispensed to pregnant women?	Food vouchers dispensed:	
	Weekly, every 2 weeks, no response or not applicable	0
	Monthly or longer interval	-1
8. At what interval do pregnant clients usually return to your WIC site for services after their initial visits?	If women return for services:	
	Monthly or no set interval	0
	Less than monthly or no response	-1
9A. Does your WIC site provide or arrange transportation for clients to and from the WIC site?	Yes	1
	No	0
9B. Does your WIC site provide or arrange on-site child care during mothers' visits to the site?	Yes	1
	No	0
16. Number and type of staff members at your WIC site who are paid in full or in part with WIC Program funds...		
and	Total # staff terminated / Total # full & part time staff	X 100
18. How many staff at your WIC site (paid in full or in part with WIC funds) resigned, retired, or were terminated during calendar year 1982?		
	≤ 14	1
	≥ 17 and ≤ 44	0
	≥ 50 or no response	1
Box for nutrition education	Nutrition Education:	
	Provided	0

	Not provided	-3
Forms Attached:		
Progress notes	Yes	0.5
	No	0
Nutrition assessment sheet	Yes	0.5
	No	0

Exhibit C: Clinic Administrator Questionnaire

Question	Scoring System: Response	Points
6. Is nutrition education or advice provided by this clinic?	Nutrition Education:	
	Provided	0
	Not provided	-1
8. Does this clinic provide food supplements to any pregnant patients, directly or through coupons, stamps, or commodity donations?	Food supplements:	
	Provided	1
	Not provided	0
10. (Column B, other hours) All times each day that the prenatal clinic is open for patient services...	If hours open include:	
	Any weekend hours or hours other than 9 to 5	1
	Only weekday, 9 to 5 hours	0
15. Total number of full and part time staff employed at your prenatal clinic during past month...		
and	Total # staff terminated / Total # full and part time staff	
17. How many staff at your clinic resigned, retired, or were terminated during calendar year 1982?	0	
	>1 and $\leq$ 10	0
	$\geq$ 11	-1
Forms attached: Progress notes		
	Yes	0.5
	No	0

Exhibit D: Nutrition Education, WIC Site Administrator And Clinic Administra
Questionnaires Combined

Question	Response	Scoring System Point
`For each of the languages listed below, please enter the percentage of your total patients who speak the language as their principal language. Chinese English French, Haitian, Creole German Italian Portuguese Spanish Vietnamese and "other" Asian (Cambodian, Laotian, Thai, Korean, Hmong) Other: Russian Other: Polish Other: Specified (Question 14 on the WIC Site and Clinic Administrator Questionnaire and Question 6 on the Nutrition Education Questionnaire.)	For each foreign language if more than 0% of clients speak the language as principal language: Nutrition education presentations: given in that language not given in that lang. No clients with principal language other than English	 1 -1 0
7. (Nutrition Education Questionnaire) What is the total number of staff members who provide nutrition education or advice? and 3.1a (WIC Site Administrator Questionnaire) Number of new pregnant clients certified at your clinic each month...	Number of staff providing nutrition education / Number of new pregnant clients x 100 >0 and ≤10 or Missing ≥11 and ≤ 20 ≥ 21 and ≤ 38 ≥ 39	 0 1 2 3
7. (Nutrition Education Questionnaire) What is the total number of staff who provide nutrition education or advice? and 4. (Clinic Administrator Questionnaire) In an average month, about how many pregnant women register to begin services at this clinic?	Number of staff providing nutrition education/advice / Number of new pregnant clients x 100 >0 and ≤5 or Missing >6 and ≤15 ≥ 16 and ≤ 38 ≥39	 0 1 2 3

APPENDIX IV-B: FIELD PROCEDURES MANUAL

THE NATIONAL WIC EVALUATION:

A STUDY OF HEALTH AND NUTRITION OF MOTHERS AND THEIR CHILDREN

FIELD PROCEDURES MANUAL

January, 1983

Research Triangle Institute/New York State Research Foundation

E. Anthropometry Protocol

1. Overview

a. The Importance of Anthropometry to the Evaluation Study

Anthropometry, the measurement of body size, weight, and proportions, is one of the best indicators of the nutritional status of pregnant women, infants, and children. Trends revealed through anthropometric data help track individual growth, detect growth abnormalities, monitor nutritional status, and evaluate the effects of nutritional intervention on the treatment of disease.

Anthropometric measurements will be recorded for all participating women and on all eligible children. The purpose of these measurements is to assess the effects of WIC intervention on fetal growth (reflected by maternal weight gain during pregnancy), birth weight, and growth in infancy and early childhood. Anthropometry also will allow determination of the differences in rates between WIC and non-WIC participants in growth retardation, thinness (underweight) and obesity in preschoolers.

This evaluation will attempt to define how much effect the WIC program has (e.g., are there 10 percent fewer low birth weight children born to WIC than to non-WIC women?). It will also determine if these effects are beneficial (e.g., preschool WIC participants have a lower prevalence* of obesity than do non-WIC preschoolers) and therefore should be promoted; or if they are detrimental (e.g., preschool WIC participants have a higher prevalence of obesity than do non-WIC preschoolers), thereby indicating a need for improvement of a particular aspect of the program; or if they are ineffectual (i.e., no difference in outcome measures, such as anthropometry, between WIC participants and controls).

b. Measurement Error Concerns

Anthropometric measurements must be made accurately and recorded correctly, particularly for detection of the small expected effects resulting from short-term nutritional supplementation of a mildly malnourished population. Errors of .25 kilograms (kg) or about .50 pounds (lb), .5 centimeters (cm) or about 1/8 inch, or 1 millimeter (mm) or about 1/25 inch, can easily obscure the effects WIC intervention may have on growth. Errors of this magnitude may be five or more times greater than the effects we expect to find for some groups. In preschoolers, errors of .5 kg, 1.0 cm or 2 mm can result in misclassifications of obesity, thinness, and growth retardation.

Various measurement errors may not tend to average out, either for individuals or groups. Instead, those errors may be compounded. For example, in clinics where there are many stature (height or length)

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* $\text{Prevalence} = \frac{\text{Number of Existing Cases}}{\text{Number of People Measured}} \times 100$

measurement errors, young children are commonly measured too short because of difficulties in obtaining an appropriate measuring position. Since weight measurements generally are more accurate than stature in this situation, an artificially high proportion of children are reported as being overweight for their stature. The most common and important causes of measurement errors are related to equipment, technique, and motivation.

Equipment-related errors are usually attributable to:

- the use of improper and inadequate equipment, such as bathroom and other spring scales; yardsticks and stretchable tapes that are not properly positioned on a table or wall, and damaged calipers where the needle no longer returns to "0"
- incorrect use of equipment (e.g., failure to periodically check the zero balance on scales, calibrate calipers, etc.)
- inadequate maintenance of proper equipment, such as the use of worn, loose, or broken equipment.

Technique-related errors require special attention because taking anthropometric measurements, particularly height and weight, appears to be so much easier than it is. Some common errors in technique include:

- measuring the length of infants and young children when they are not properly positioned or extended
- measuring squirmy or unmanageable children without seeking parental assistance and waiting until the child calms down
- measuring the crown of the woman's or child's head when the head is not firmly touching the headboard
- measuring incorrect sites for skinfolds, arm, or head circumferences because of careless site selection.

Technique-related errors are often the result of misreading the measures, being interrupted before recording the measurement (i.e., failing to record measurements immediately), or inadvertently transposing the digits when writing them down. Specific equipment and technique-related errors to be avoided are described in the procedures and definitions for each type of measurement.

Proper knowledge of equipment, its maintenance, and of correct procedures can help reduce the chances of measurement and recording errors. But, only through practice and periodic checking of equipment and skills, can reliability--that is, the precision and accuracy of measurements--be achieved and maintained.

Precision is the extent to which the same measurement is obtained on repeated trials. For example, a measurement repeated three times, yielding the same reading each time, indicates perfect reliability.

Readings that fluctuate widely over repeated trials indicate poor reliability. Accuracy is the nearness of a measurement to the true value. In practice, accuracy can be closely achieved by a trained individual using proper equipment and proper techniques.

Measurements may be precise and still not be accurate because of inadequate equipment or improper technique. Anthropometric data must be both precise and accurate, so attention to proper equipment, procedures, and motivation is essential. Motivation-related errors are generally caused by the data collector's failure to recognize the need for reliability, and by lack of feedback to data collectors on their application of techniques and the reliability of the measurements they record.

2. Women's Measurements

Weight, height, triceps and subscapular skinfold thickness, and the arm circumference of each participating woman will be measured and recorded on the Women's Measurement Form (Figure III-20), which is included in the Women's Initial Interview Package. You will be instructed in standard anthropometric techniques for measuring height and weight. When required, you will instruct WIC and prenatal clinic staff by demonstrating these techniques and providing written instructions for their use.

Field operatives will take all anthropometric measurements on sample women whenever possible. This will be possible at clinics that allow the operative to take measurements for them or to take measurements for the study even though clinic staff prefer to take their own for the clinic records. Field supervisors will inform operatives about clinic arrangements regarding anthropometric measurements.

It will not be possible for you to obtain all measurements in those clinics that will not allow you to take anthropometric measurements or when you are unable to get to the clinic before an identified eligible woman leaves. In such circumstances, you should abstract the clinic measurements for weight and height from the records and record them in Items 2 and 3 on the Women's Measurement Form. Items 8-A. and B. should then be coded "01" to indicate that the measurements were abstracted. Any problems that you are aware of that might have affected the accuracy of the measurement should also be noted in the comments section of the measurement form. All other required measurements should then be made during a visit to the sample woman's home.

In preparation for recording measurements, record on the measurement form the name of the sample woman and the date on which the measurements are being taken. Then complete the form following specifications presented in Section B.5 of this chapter.

Figure III-20

WOMEN'S MEASUREMENT FORM

NAME (FIRST, MIDDLE, LAST): Aurora Maria Martinez

DATE OF MEASUREMENTS: Month 03 Day 09 Year 83

1. TYPE OF CLOTHING DURING WEIGHT
   - Gown and slippers 01
   - Light street clothing . . . (02)
   - Other (SPECIFY) 03

   _____

2. WEIGHT ___ . __ lb. OR 061 . 80 kg.

3. HEIGHT __ __/8 in. OR 163 . 2 cm.

4. LEFT ARM CIRCUMFERENCE 25 . 6 cm.

5. LEFT TRICEPS SKINFOLD

   (a) 16 . 5 mm.
   (b) 16 . 0 mm.

   IF MEASURES DIFFER BY MORE THAN 3 mm., TAKE THIRD MEASURE.

   (c) __ . __ mm.

6. LEFT SUBSCAPULAR SKINFOLD

   (a) 12 . 5 mm.
   (b) 13 . 0 mm.

   IF MEASURES DIFFER BY MORE THAN 3 mm., TAKE THIRD MEASURE.

   (c) __ . __ mm.

7. COMMENTS ON MEASUREMENTS: _____

8. A. WEIGHT WAS...
   - Abstracted from record . . . . . (01)
   - Taken by operative 02

   B. HEIGHT WAS...
   - Abstracted from record . . . . . (01)
   - Taken by operative 02

9. ESTIMATE THE TOTAL NUMBER OF MINUTES REQUIRED TO TAKE MEASUREMENTS AND ABSTRACT DATA.

   06 Minutes

a. Equipment Needed

The following equipment will be needed at the clinic to complete women's measurements during the initial interview:

- beam balance scale marked in increments of .10 or .25 pounds, or 0.1 kilograms (100 grams)*
- stature device marked in eighths of an inch, with unattached sliding headboard
- tape, washer, and thread
- Lange skinfold caliper and calibration block
- two insertion tape measures, marked in millimeters
- fine point felt tip pen with black ink
- number 2 lead pencils.

It is expected that a suitable beam balance scale will be available at each clinic and that you will provide the other required equipment. Should the proper scale not be available for use at a clinic, you will be responsible for using similar equipment supplied by RTI.

You will be responsible for installing the stature devices (see Figure III-21) at all clinics assigned to you. You will receive, for each clinic assigned, a four-foot measuring stick with double-sided tape on the back, a washer with a long piece of thread, and the headboard of the device.

To install the measuring stick, find an appropriate wall (flat surface with no moldings above 4' from the floor) against which you can place and measure a woman. With one hand hold the measuring stick perpendicular to the floor about one inch away from the wall. With the other hand place the headboard so that it rests firmly on top of the measuring stick with the back of the headboard against the wall. Remove your hand from the measuring stick, allowing the pressure of the headboard to maintain the measuring stick upright. Do not place so much pressure on the headboard that the measuring stick bends under the pressure. With your free hand gently draw a line with a pencil across the wall, using the bottom edge of the headboard as a guide. Take the headboard away and use the measuring stick to check the distance from the floor to the line you have drawn. The pencil line should be exactly 4' from the floor. If the pencil line is not exactly 4' from the floor, repeat the process above until your line is at the proper distance from the floor.

Then take the end of the thread without the washer attached and hold it against the wall about 3' above the pencil line you have drawn.

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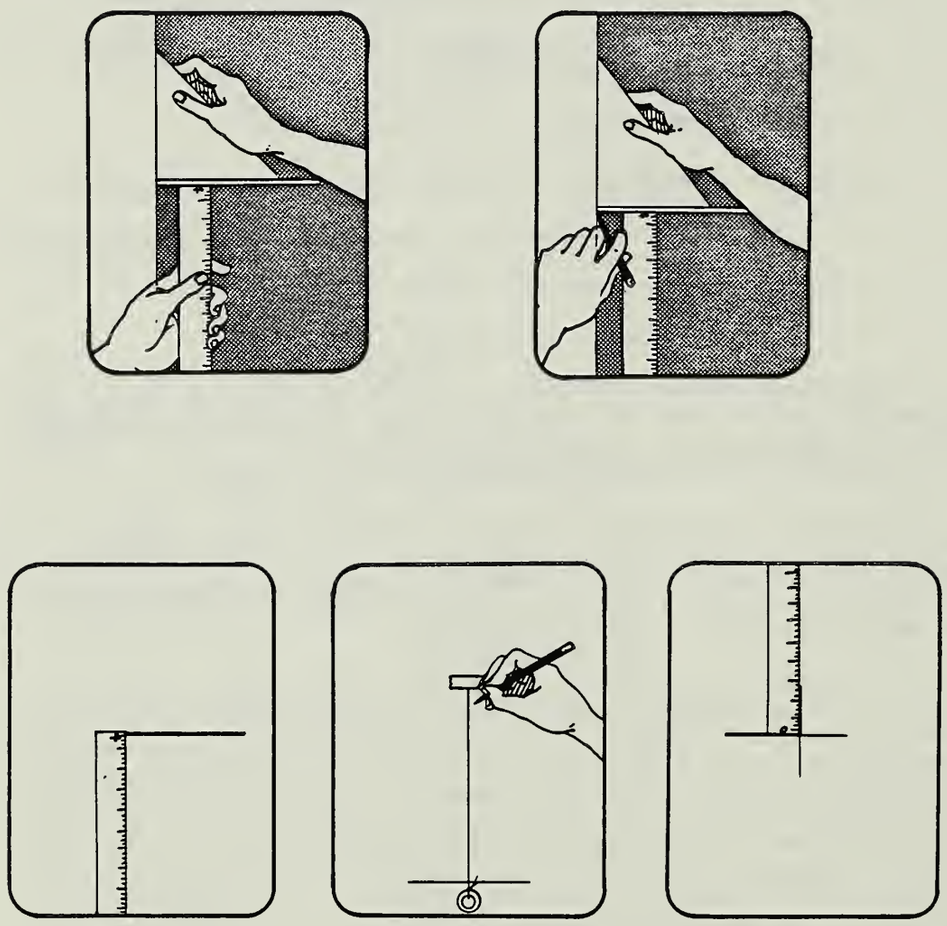
*Weight will be measured to the nearest .50 lb. or .25 kg. only if this is the finest increment of the beam balance scale available at the clinic.

Figure III-21

Installing the Stature Device



Allow the washer to hang free. Tape the top end of the thread to the wall about 3' above the pencil line. Mark a vertical line at the top and near the bottom of the thread. Connect the lines by a pencil line using the measuring stick. Then place the unnumbered edge of the measuring stick flush against the vertical pencil line. Make sure the zero (bottom) end of the measuring stick is at the level of the horizontal 4' line. Peel the backing from the tape and press the measuring stick firmly against the wall. Leave the headboard in a convenient place in the clinic where it is unlikely to be lost or taken.

b. Measurement Procedures

Each required measurement must be taken following the procedures described and, preferably, in the order in which the procedures are listed. All results are to be recorded on the Women's Measurement Form immediately after the measurement is made.

Weight is to be measured to the finest gradation possible (e.g., to the nearest .10 or .25 lbs. or .10 kg for women); height is to be taken to the nearest eighth of an inch; arm circumference is to be taken to the nearest tenth of a centimeter (millimeter); and skinfolds are to be estimated to the nearest half of a millimeter (0.5 mm).

Arm circumference and skinfolds are to be taken on the left side of the body, if possible. When measurements cannot be taken on the left side because of casts, amputations, or other reasons, these particular measurements should be made on the right side and the reasons noted in Item 7 of the Women's Measurement Form.

The measurements are to be made in the following order since partial removal or rearrangement of clothing is required for all measures except height:

- height
- weight
- arm circumference
- triceps skinfold
- subscapular skinfold.

Detailed procedures for taking and recording each measurement and using the equipment follow. It is important to follow the instructions exactly. You should use these procedures, which are standard anthropometric techniques, as a checklist for each measurement that is taken. The measurements should be taken in a room that affords privacy as removal of some clothing is necessary for measuring weight, arm circumference, and skinfolds. Blouses and zippered dresses should be unbuttoned or unzipped and pulled down and shift type dresses should be pulled up or off when measuring arm circumference and skinfolds. Women should be asked to remove all street clothing down to the minimal layer of outer clothing (e.g., skirt and blouse or dress and stockings), and to remove all heavy outer wear such as shoes, sweaters, vests, bracelets, hats and other headwear. However, women will always be weighed in gowns and bare or stocking feet in clinics where this is the routine procedure.

(1) Weight Measurements

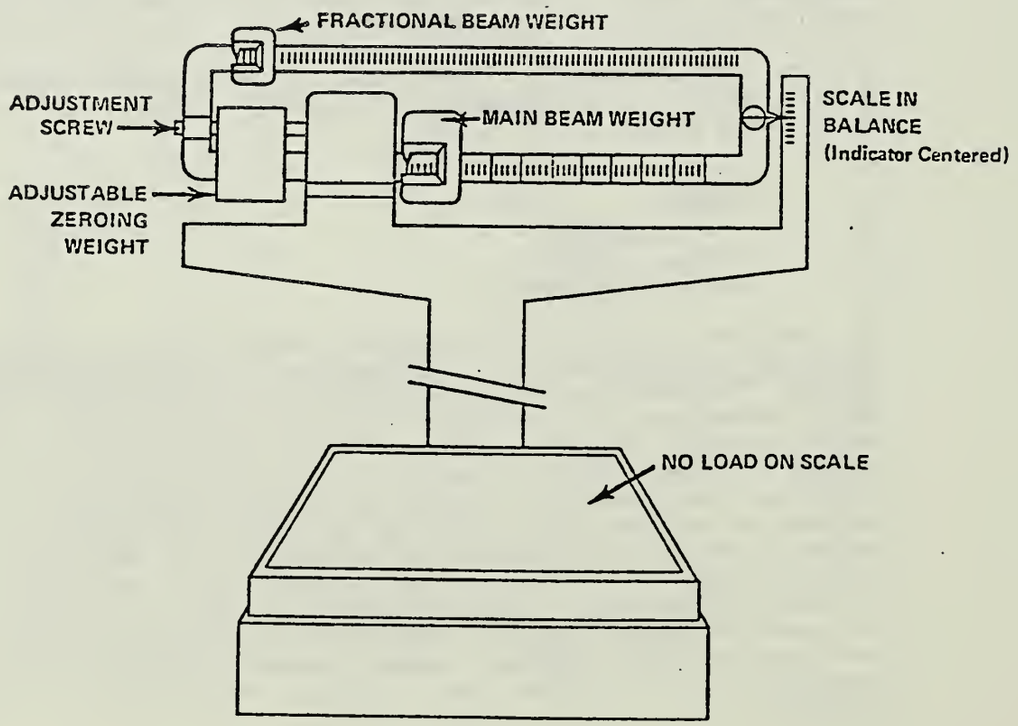
Before weighing each study participant the horizontal beam of the beam balance scale must be calibrated at zero. To do that, remove everything from the scale. Place the main and fractional sliding beam weights directly over their respective zeros and, using the adjustment screws, move the adjustable zeroing weight until the beam is in zero balance (see Figure III-22). When the scale is not in use, to preserve the edge of the measurement fulcrum, do not leave the beam weights on zero.

The steps in obtaining the woman's weight are:

- Confirm that the sliding weights on the horizontal beam are at the zero position and that the scale is in balance. If the scale is not in zero balance, it should be balanced by adjusting the zeroing weight.

- The woman should be asked to stand still in the middle of the scale with her weight evenly distributed on both feet. Make sure that she is standing free without holding on to anything.

Figure III-22
Beam Balance Scale



- Move the weight on the main beam away from the zero position until the indicator indicates that too much weight has been added (Figure III-23); then move the weight back towards the zero position until just barely too much weight has been removed (Figure III-24).

Figure III-23

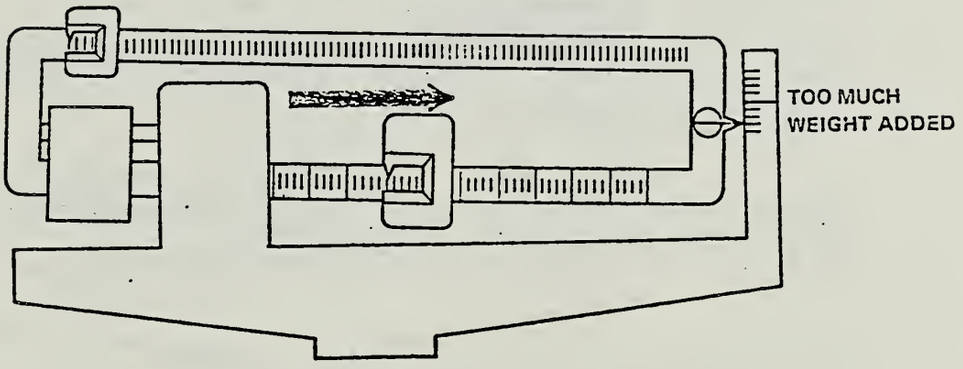
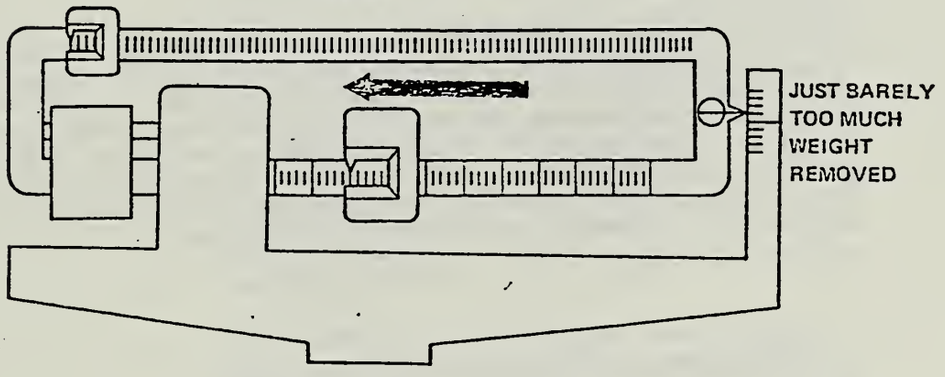
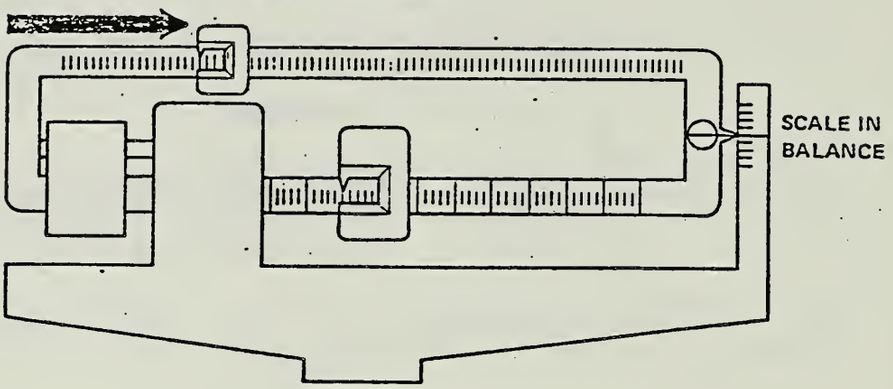


Figure III-24



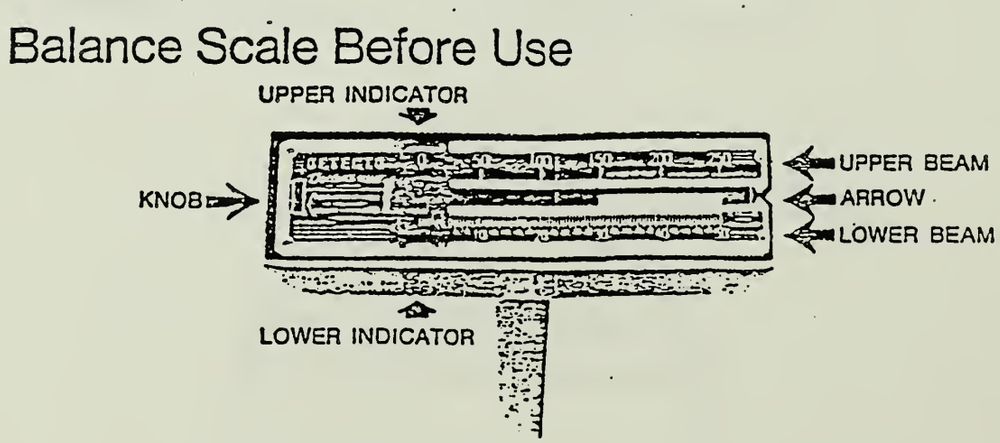
- Move the weight on the fractional beam away from its zero position until the indicator is centered (Figure III-25), indicating that the woman and the weights are in balance with each other. This may require several back-and-forth adjustments of the fractional weight.

Figure III-25



- Wait until the scale pointer stops moving. A swinging pointer may be restricted but <u>never</u> stopped by a finger. Most beam balance scales have the main beam on top and the fractional beam on the bottom, although some such as the Detecto Doctor's Scales, do not (Figure III-26). The method of positioning the indicators is still the same; the main beam (whether on top or bottom) is still the first to be adjusted, after which the fractional beam indicator is adjusted.

Figure III-26



- Read the weight to the finest graduation of the scale, i.e., to the nearest .10 or .25 lb. or 0.10 kg. Only when the finest increment of the scale is .50 lb. or .25 kg. may you read the weight to these increments.

- Record the weight in Item 2 of the measurement form immediately. If the scale uses pounds as its unit, use the boxes for weight in pounds. If the scale uses kilograms as its unit, use the boxes for weight in kilograms. Take care to record in the right units and boxes since you may use scales that measure in different units at different clinics. Always record the weight in five digits and fill in the blank boxes with zeroes as appropriate (e.g., 98.5 should be entered as 098.50).

- If the woman weighs more than the scale can measure, usually 400 pounds or 180 kilograms, ask her to estimate her weight and record that weight was estimated (WT EST) in Item 7 of the measurement form.

(2) Height

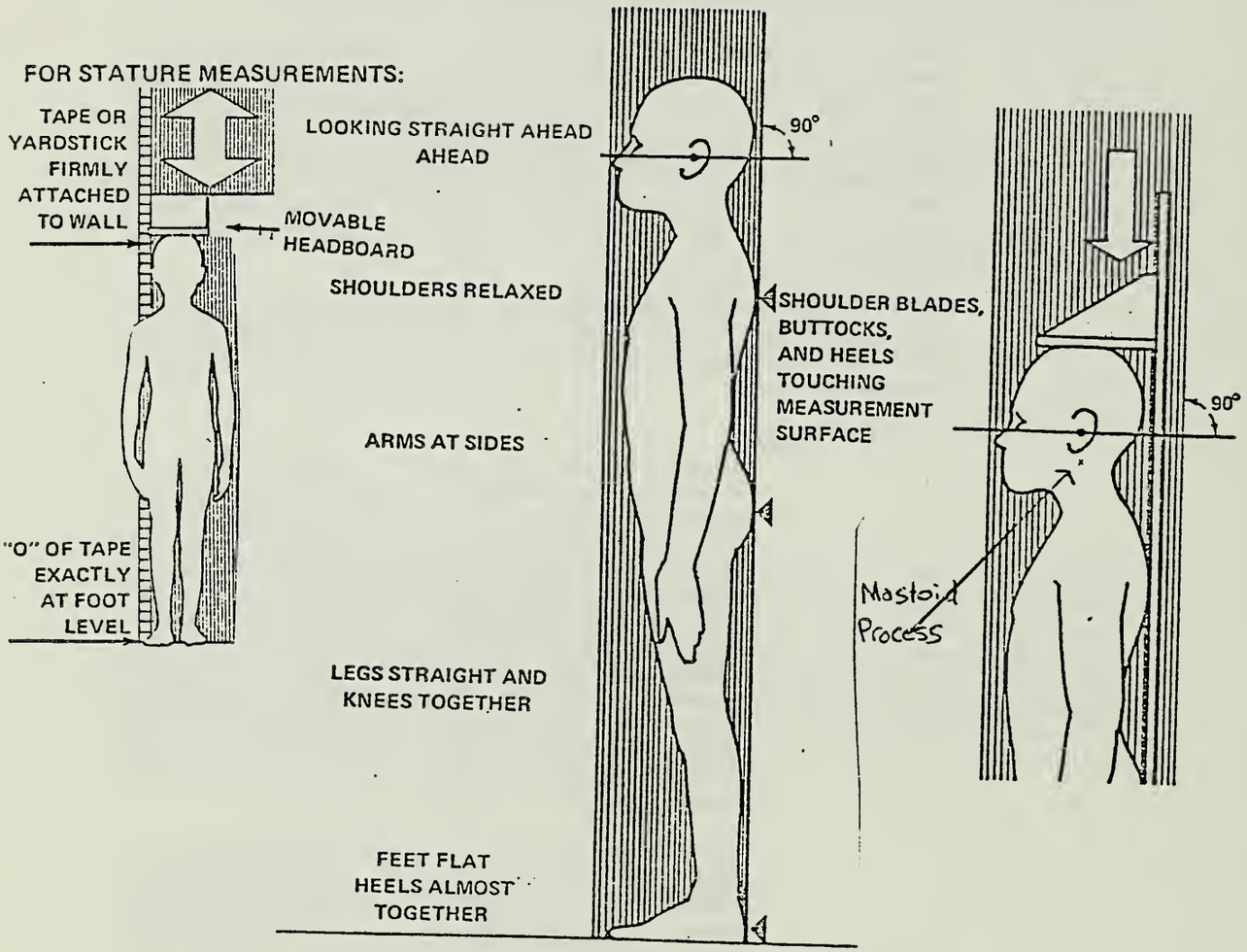
- Always measure the woman's height in bare or stocking feet--NEVER in shoes, sandals, or household slippers. Have the woman stand erect with her back, heels and head against the wall with the side of her head next to the measuring stick on the wall. Tell her to "Stand up tall" or "Stand up straight." Heels should be together, with feet at approximately a forty-five degree angle. The woman's head should be placed so that the Frankfort Horizontal Plane is parallel to the floor. The Frankfort Plane is an imaginary line between the top of the external auditory meatus (ear hole) and the bottom of the orbit (eye socket).

  Some women may have buttocks that protrude to such a degree that when the correct position against a wall is assumed they are not standing erect. In such cases the woman should stand away from the wall just enough to stand erect maintaining as much contact with the wall as possible. Some women will not be able to stand erect with heels together. For these cases, feet should be as close together as possible when the woman assumes an erect posture. Women should be asked to take a deep breath just before you take the measurement.

- Grasp the woman under the mastoid processes* with one hand (see Figure III-27). With the

*The mastoid processes are located approximately 1½ inches directly below the ear hole on the bone projecting from the side of the head.

Figure III-27



other hand bring the movable headboard down snugly to the woman's head, being careful not to make her shrink with the pressure. The side of the headboard should be maintained against the measuring stick when reading the measurement. Read the measurement corresponding to the bottom edge of the headblock.

- Always remember to add 48 inches to the height reading when you use the measuring stick you have installed.

- Record the standing height in Item 3 on the measurement form immediately after reading the measurement. This should be recorded in three digits to the nearest 1/8 inch. For example, 61 inches exactly should be recorded as [6][1][0] /8 in. Similarly, 65½ inches should be recorded as [6][5][4] / 8 in.

(3) Arm Circumference

With the woman standing erect, her left arm flexed 90° at the elbow, use one of the insertion tapes to define the center point between the upper edge of the acromion process (the highest point of the shoulder) and the olecranon process of the ulna (point of the elbow). Mark this midpoint carefully with a felt tipped pen. This is the level at which both the arm circumference and triceps skinfold are to be measured. Arm circumference is measured at the midpoint immediately below the marked point. Ask the woman to let her arm hang freely at her side; then fit the tape around her arm. The tape should be fitted snugly without skin dimpling, perpendicular to the long axis of the arm and parallel to the floor. Check that the tape fits firmly with uniform contact made with the skin surface, so that the tape won't slip on the arm, but without compressing the soft tissues of the area. Measurements are made to the nearest millimeter and read from the marker arrow on the insertion tape. Record this measurement in Item 4 of the measurement form.

(4) Triceps Skinfold

Have the woman stand erect, relax her shoulders, and let her arm hang freely at her side. Using the marked point on the left arm, grasp the skin and subcutaneous (just beneath the skin) tissue firmly with thumb and forefinger 1 cm above the mark and draw directly back from the body making sure that no muscle tissue is included in the fold. The measurement is to be taken directly over the triceps muscle. The crest of the fold should be parallel to the long axis of the arm. Apply the caliper at the level of the point marked and at the base of the fold without including any muscle in the fold. Gently release the lever of the caliper and, after 2-3 seconds, estimate the fold to the nearest 0.5 mm without releasing the fingers. Release the fold from the calipers and your fingers. Enter the measurement in Item 5(a) of the measurement form. Wait a few seconds and put the first triceps skinfold reading out of your mind. Now, take a second measurement following the same procedures. Enter the result of the second measurement in Item 5(b). Subtract the second result from the first; if they differ by more than 3 mm, take a third measurement and enter the result in Item 5(c).

(5) Subscapular Skinfold

Have the woman stand erect and relax her shoulders and arms. Palpate the inferior angle of the scapula (shoulder blade). Grasp a fold of skin and subcutaneous tissues directly above the angle firmly with the thumb and forefinger and draw straight back from the body making sure that no muscle tissue is included in the fold. The fold should parallel natural cleavage lines of the skin (between the bottom of the shoulder blade and the rib), which are often about 45° from the horizontal extending medially upward. Apply the caliper about 1 cm below the thumb and forefinger at the base of the fold without including any muscle in the fold. Gently release the lever of the caliper and estimate the fold to the nearest 0.5 mm without releasing the fingers. Release the fold from the calipers and your fingers. Record the measurement in Item 6(a). Wait a few seconds and put the first subscapular skinfold out of your mind. Take a second measurement following the same procedures and enter the result in Item 6(b). Subtract the result of the second measurement from the result of the first. If the difference is more than 3 mm, take a third measurement and enter the result in Item 6(c).

c. Monthly Weight of Clothing Requirement

On your first working day of each month at all clinics where gowns are routinely used, you will ask all eligible women seen that day to undress down to their underclothes (bra, panties, slip, stockings) to be weighed. The womens' weight should be described as "gown and slippers" (paper slippers only or bare or stocking feet) and recorded on the measurement form. Put the woman's light street clothing (no coats, shoes, or outer garments) in a paper bag and weigh the clothing. The weight of the clothing is to be recorded on the Weight of Clothing Form (Figure III-28) beside the participant's ID number. Circle the proper code to indicate if the woman was weighed at the clinic; if so, code who weighed her (operative vs. clinic staff).

This data will provide an estimate (by clinic and season) of the weight of light clothing that will be used in analysis of weight measurements. This procedure can be done only in clinics where a private room for changing and weighing exists and is available on your first working day at the clinic each month.

3. Children's Measurements

Weight, length or height, arm and head circumferences, and triceps and subscapular skinfold measurements will be taken and recorded for all eligible children. These measurements will be made in the children's homes as part of home visits scheduled during the initial interviews with sample mothers. Measurements are to be recorded on the Child's Measurement Form (see Figure III-29).

The clothing of infants, including diapers, should be removed before the children are weighed. Children two years and older should remove all clothing except underpants. Refer to Appendix D for some additional information about techniques for measuring children, hygiene, and other considerations.

Figure III-28

WEIGHT OF CLOTHING FORM
A Study of Health and Nutrition
of Mothers and Their Children

DATE OF THIS REPORT

Month	Day	Year
03	01	83

PSU #	CLINIC #	OPERATIVE NAME	ID #
3478910	20173	Mantha Smith	3147982

FOR EACH WOMAN SCREENED AS ELIGIBLE ON THE DATE ENTERED ABOVE, COMPLETE APPLICABLE PARTS OF A NUMBERED ROW BELOW.

ID NUMBER	WAS THIS WOMAN WEIGHED TODAY?	WHO WEIGHED HER?	WEIGHT OF CLOTHES
(1) 2000432	Yes . . . (01) No . . . 02 (NEXT ID)	Clinic Staff . . . 01 Operative. . . . . (02)	01 · 75 lb. OR . kg.
(2) 2000516	Yes . . . (01) No . . . 02 (NEXT ID)	Clinic Staff . . . 01 Operative. . . . . (02)	02 · 50 lb. OR . kg.
(3) 2000649	Yes . . . (01) No . . . 02 (NEXT ID)	Clinic Staff . . . 01 Operative. . . . . (02)	02 · 00 lb. OR . kg.
(4)	Yes . . . 01 No . . . 02 (NEXT ID)	Clinic Staff . . . 01 Operative. 02	· lb. OR . kg.
(5)	Yes . . . 01 No . . . 02 (NEXT ID)	Clinic Staff . . . 01 Operative. 02	· lb. OR . kg.
(6)	Yes . . . 01 No . . . 02 (NEXT ID)	Clinic Staff . . . 01 Operative. 02	· lb. OR . kg.
(7)	Yes . . . 01 No . . . 02 (NEXT ID)	Clinic Staff . . . 01 Operative. 02	· lb. OR . kg.
(8)	Yes . . . 01 No . . . 02 (NEXT ID)	Clinic Staff . . . 01 Operative. 02	· lb. OR . kg.
(9)	Yes . . . 01 No . . . 02 (NEXT ID)	Clinic Staff . . . 01 Operative. 02	· lb. OR . kg.

Figure III-29

CHILD'S MEASUREMENT FORM

DATE OF MEASUREMENT	START TIME
Month 03 Day 10 Year 83	9:16 (am) / pm

1. How tall is (CHILD'S) father? RECORD FEET AND INCHES: 5 ft. 08 in.

2. WEIGHT 25 lb. 03 oz.

3. STANDING HEIGHT ___ . ___ cm.

OR

RECUMBENT LENGTH 86 . 8 cm.

A. PLOT WEIGHT AND HEIGHT ON APPLICABLE CHART. TAKE SECOND MEASUREMENTS IF CHILD'S WEIGHT FOR HEIGHT IS LESS THAN 5TH PERCENTILE OR MORE THAN 95TH PERCENTILE.

WEIGHT ___ lb. ___ oz.

HEIGHT ___ . ___ cm.

OR

LENGTH ___ . ___ cm.

4. HEAD CIRCUMFERENCE 48 . 1 cm.

5. LEFT ARM CIRCUMFERENCE 16 . 0 cm.

6. LEFT TRICEPS SKINFOLD

IF MEASURES DIFFER BY MORE THAN 2 mm., TAKE THIRD MEASURE.

(a) 10 . 0 mm.

(b) 10 . 5 mm.

(c) ___ . ___ mm.

7. LEFT SUBSCAPULAR SKINFOLD

IF MEASURES DIFFER BY MORE THAN 2 mm., TAKE THIRD MEASURE.

(a) 06 . 5 mm.

(b) 06 . 0 mm.

(c) ___ . ___ mm.

8. COMMENTS ON MEASUREMENTS: _____

End Time 9:22 (am) / pm

CONTINUE WITH TESTS FOR 4- AND 5-YEAR OLDS.

a. Equipment Required

You will be furnished with the following equipment to complete children's measurements:

- portable Chatillon beam balance scale
- child length-height device marked in millimeters
- Lange skinfold caliper and calibration block
- two insertion tape measures marked in millimeters (equal to 0.1 cm.)
- fine point felt tip pen
- number 2 lead pencils
- paper towels.

b. Procedures for Measuring Children

(1) Weight

All children are to be weighed on the portable beam balance scale (Figure III-30) provided by RTI. You must check frequently and adjust, when necessary, the zero weight on the horizontal beam of the scale. Adjustments are made by first, leveling the scale using the adjustable feet* and second, by placing the main and fractional sliding weights at their respective zeros and turning the zeroing screw until the beam is in balance with the indicator at zero (this can be done with a key or a dime).

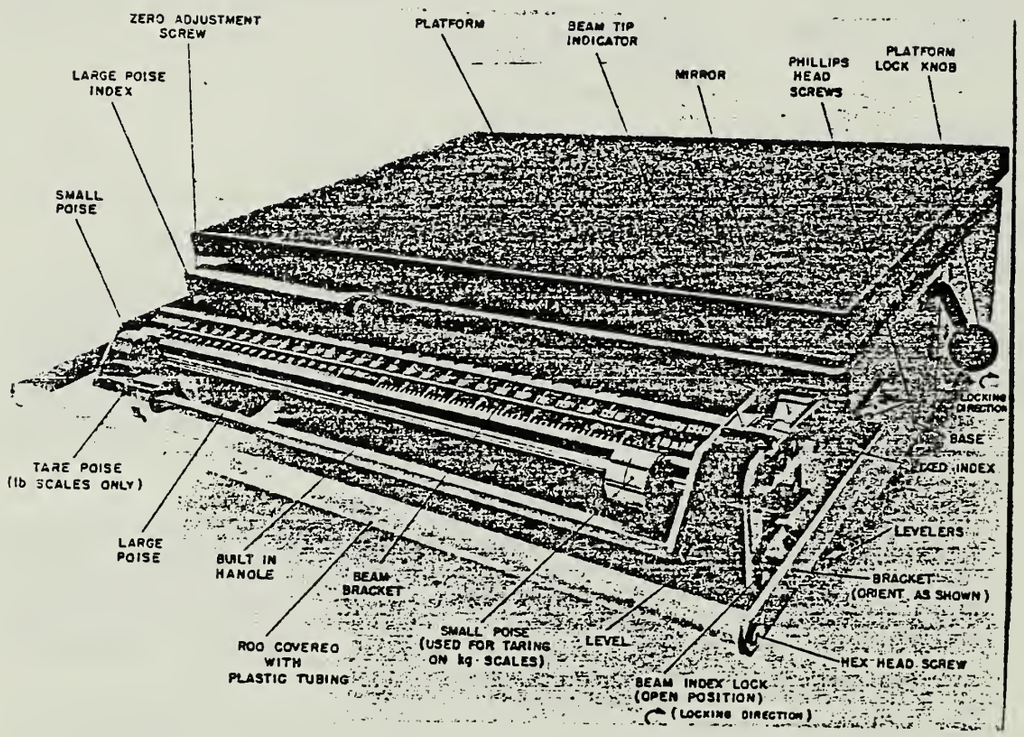
For infants and young children who cannot stand, place a single layer of paper towels on the scale platform, then lay the child on his/her back on the platform or have the child sit on the center of the platform. Older children should stand still in the middle of the scale's platform with weight evenly distributed on both feet. Make sure the child is standing free without holding on to anything.

The infant's clothing should be removed before the infant is weighed. (When the temperature inside the child's home is cold enough to cause him/her noticeable discomfort, follow the instructions in Appendix D for cold weather weighing.) Make sure the scale reads zero when not weighing. Place two or three paper towels on the center of the platform. Ask the mother how much the baby weighs and adjust the poises to one pound above the weight mentioned by the mother. The nude infant then should be placed on the paper towel in the center of the platform and weighed to the nearest ounce. The weight should be read aloud, then recorded immediately in Item 2.

If the infant moves excessively, it will be impossible to place the weights so that the beam remains steady at the balance point. An inaccurate weight measurement may result. In this case the measurement should be postponed until later in the visit. If the infant still does

*See instructions for Equipment Checks on Page III-117.

Figure III-30
Portable Beam Balance Scale



not cooperate, the measurement should be omitted unless a reasonable estimate of weight can be made. The circumstances should be noted in Item 8 of the measurement form (e.g., "Infant moving, about 17 lbs. 10 oz.").

Children who can stand without assistance are to be weighed standing on the scale, wearing only light-weight undergarments. Diapers should be removed. Stand the child over the center of the scale platform with heels together. Make the reading when the child is standing still and not touching anything; record the weight to the nearest ounce. The weight should be read aloud and recorded in Item 2 of the measurement form.

(2) Stature

(a) Length

Recumbent (lying down) length is to be measured for children younger than 24 months and for children between 24 and 36 months of age who cannot stand unassisted. The measurement should be made on a table or other flat, wooden or formica-type surface (not floor), using the child length-height device held parallel to the surface. The device has a measuring stick with an attached tape marked in millimeters and an attached, collapsible board at the tape's zero end. Length is recorded as the distance between the headboard and footboard when the infant has been positioned properly. When you are reading the tape, read and record the last completely visible number plus the fractions of centimeters up to the board.

Two people will be required for measuring an infant's length (Figure III-31). One person, possibly the mother, should hold the infant's head so the infant is looking vertically upward with the crown of his/her head placed firmly against the attached headboard (this board is now folded out to stand at a 90° angle to the measuring stick). Be sure that the infant's trunk and pelvis are properly aligned with the measuring device. Then, gently straighten the infant's legs, hold the feet together with toes pointed directly up, and slide the movable block up, guided by the measuring stick, firmly against the feet. Check to make sure the infant's body is not arched, the knees are not bent, the feet are vertical to the movable board, and that the board is firmly against the heels of the child's feet. Read the measurement indicated by the forward edge of the footboard and record it on the Child Measurement Form.

Figure III-31
Measuring Recumbent Length

Length should be recorded to the nearest 0.1 cm (1 mm) on the measurement form in Item 3, in the space labeled Recumbent Length. If an infant is uncooperative and accuracy is impossible, the best estimate of length should be recorded along with a note in Item 8 on the measurement form explaining the circumstances. Weight for length should then

be plotted on the growth chart (see Figures III-32 and III-33). If the weight for length plot on the growth chart is more than the 95th percentile or less than the 5th percentile, weight and length should be remeasured and recorded in Items 2-3A on the form.

(b) Height

Children two years of age and older should be measured standing up, if possible. It is essential to record the measurement correctly in Item 3 (i.e., as Standing Height or as Recumbent Length), because length is greater than height by up to 2 cm. Thus, interpretation of measurements will be difficult if it is not known whether length or height was measured.

Standing height is to be measured using the child length-height device. The device should be placed with the measuring stick against the wall so the tape reads out (as in the clinics) with the attached board falling out onto the floor at a 90° angle to the measuring stick and wall. The rest of this measurement protocol is exactly the same as the protocol for measuring women's stature with two exceptions: (1) the child should stand on the attached footboard rather than on the floor, and (2) the measuring stick need not be flush against the wall. Remember, the child should stand with bare or stocking feet, assuming the same position described for mothers. Two people may be needed to measure the stature of an uncooperative child, but usually only one will be required. The measurement should be read and recorded to the nearest 0.1 cm (1 mm) in Item 3 on the measurement form. Remember that you read and record the last completely visible number on the tape plus the fractions of centimeters up to the board.

(c) Plotting Growth Charts

The Growth Charts are illustrated in Figure III-32 and 33. Note that the first one is labeled "Boys" and the second, "Girls." To plot a child's weight for stature (i.e., length or height), first find the child's stature in centimeters at the bottom of the applicable chart. With a pencil, pretend to draw an imaginary vertical line up from the child's stature to the child's weight in pounds as read on the right side of the chart. Each small block on the chart represents .50 cm. for stature and .50 pounds for weight. Mark a dot at the point on the chart where the child's stature intersects with the child's weight. For example, if a boy is 102 cm. tall and weighs 35 pounds and 5 ounces you would mark a dot at the nearest intersection, in this case, at 35.5 pounds and 102 cm.

If the dot falls below the line for the 5th percentile or above the line for the 95th percentile, remeasure weight and height and record them as noted earlier.

(3) Head Circumference

A tape with slots that form a reading window through which the end of the tape is passed will be used to measure head circumference (insertion tape measure).

Figure III-32

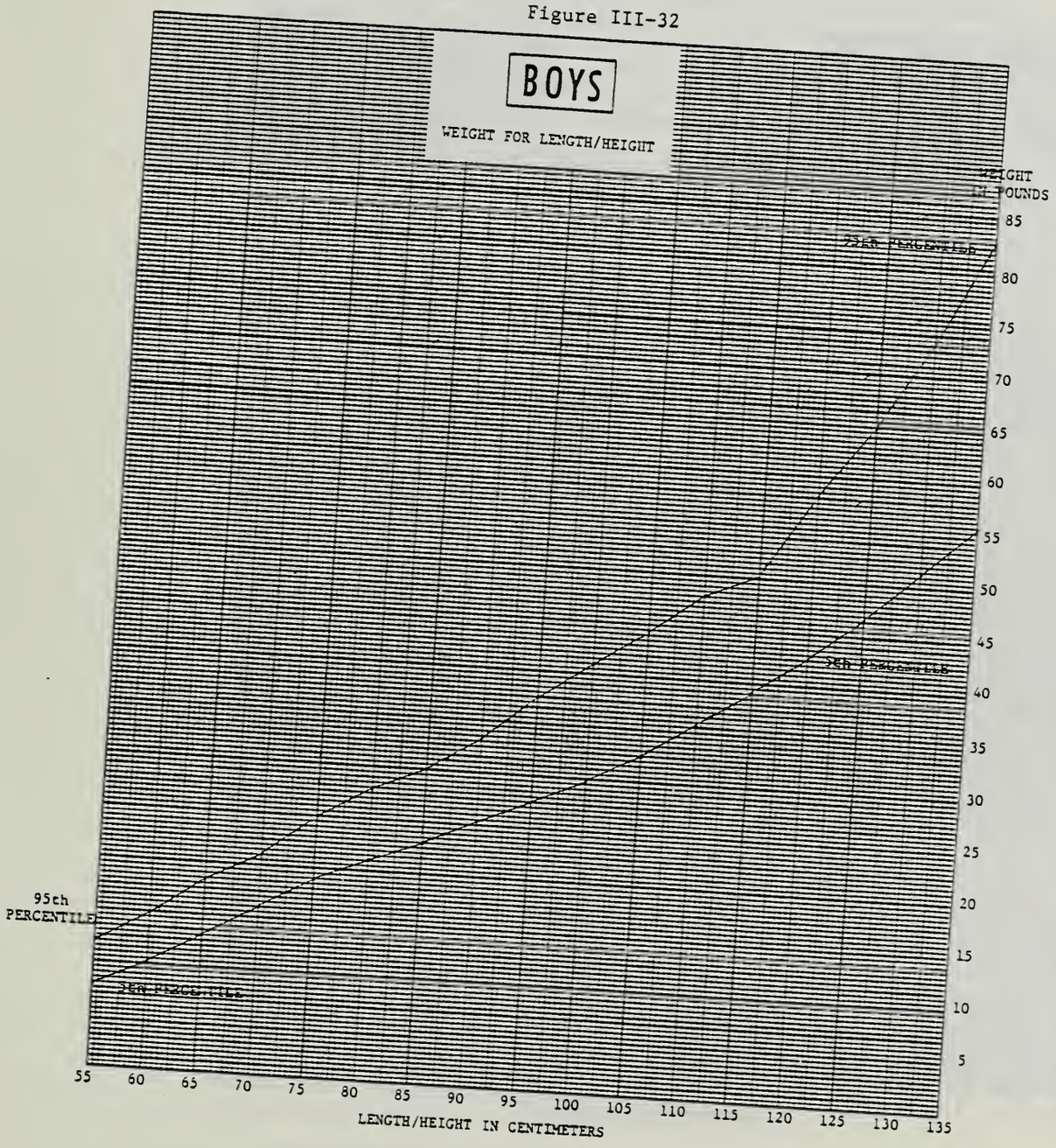
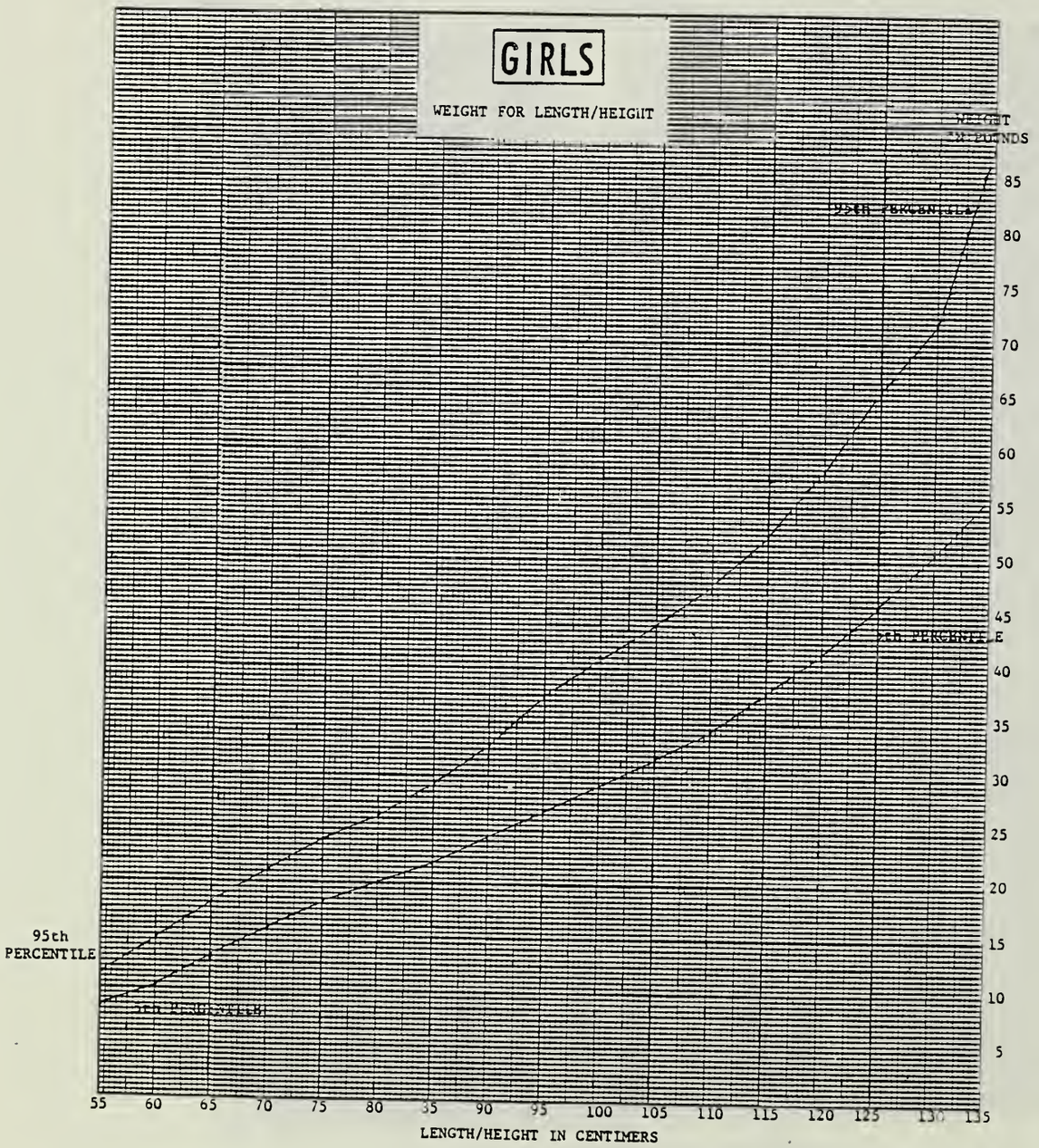
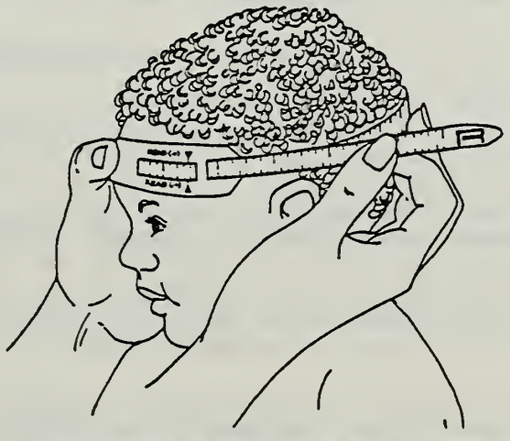


Figure III-33



Head circumference may be measured with the child sitting or standing. Position the lower edge of the tape just above the eyebrows, above the ears, and around the occipital prominence at the back of the head (Figure III-34). The tape should be pulled snug to compress the hair. The objective is to measure head circumference on a level plane. The measurement should be read and recorded in Item 4 on the form to the nearest 0.1 cm. In Item 8, note whether hairstyle did or did not prevent accurate measurement.

Figure III-34
Measuring Head Circumference



(4) Arm Circumference, Triceps and Subscapular Skinfolds

These measurements should be performed following the protocols for the measurement of arm circumference, triceps and subscapular skinfolds of women described previously. When measuring children, the subscapular skinfolds can be measured with the child sitting or standing (preferably standing). Record arm circumference, triceps and subscapular skinfold in Item 5, 6a and b, and 7a and b respectively.

4. Equipment Checks

a. Scale

Periodic calibration of your scale, using standard weights and done by an officer of each State's Inspector of Weights and Measures, may be conducted as arranged by your field supervisor.

Clinic scales must be calibrated at zero before each use. To calibrate a scale, remove everything from the platform. Place the main and the fractional sliding beam weights directly over their respective zeros and, using the adjustment screws, move the adjustable zeroing weight until the beam is in zero balance.

Spring-type bathroom scales must not be used. If a beam-balance scale is not available at a clinic, use the scale issued by RTI. If your scale malfunctions, contact your field supervisor at once.

The portable scales issued to you by RTI must also be set up properly and calibrated before use. The following steps are to be followed (see Figure III-30 for identification of scale parts):

- place scale on the surface where it will be used
- adjust the leveling legs until the bubble in the level is in the center of the black circle
- tighten locking nuts on each leveling leg
- check to see that all four legs are touching the surface on which the scale rests
- unlock the scale platform by turning lock knob toward the front of the scale
- unlock the beam lock by moving the beam index lock toward the front of the scale
- move all poise weights to the extreme left, making sure the tare poise weight is locked by its thumbscrew
- view the beam tip indicator in the polished reflector at the tip of the beam--if the scale is out of balance, turn the zero adjust screw until beam balances
- press the platform down several times and recheck for proper beam balance; readjust, if necessary.

b. Height Measurement Instruments

Check to see that the free-standing movable board slides easily and is not worn, loose, or broken. It must be held perpendicular to the measurement surface. When using the stature device (measuring stick):

- for women, always attach to a rigid surface wall without a baseboard; for children, place on a tabletop, or next to a wall
- verify that the "0" mark on the tape or measuring stick is either at the four-foot level line for the woman or at foot level if the child is measured standing or at the fixed board (head level) if the child is measured supine.

c. Insertion Tapes

Whenever an insertion tape wears out, use your back up insertion tapes and call your field supervisor to replace your worn out tape.

d. Skinfold Calipers

Lange skinfold calipers should be checked daily for accurate reading of fold size at known pressures using your calibration blocks. If the calipers are not right, adjust them by pressing firmly on the arms. If they are out of calibration by 0.5 mm, record in the comments section (Item 7 or 8) of the appropriate Measurement Form the lowest pressure at which they are out of calibration, and by how much (+ or -). If they are 1 mm or more out of calibration, record in the Comments section of the appropriate measurement form the lowest pressure at which they are 1 mm out of calibration, and if they are plus or minus (high or low). Request a replacement from your field supervisor and return the instrument that is out of calibration to RTI.

5. Replicate Measurements

Replicate (repeat) measurements should be taken on the first eligible woman you see on your first clinic work day every week. All measures (weight, height, arm circumference, and skinfolds) should be taken and recorded first on the Women's Measurement Form in the interview package. Wait a few seconds after recording all the measurements and try to put the first readings out of your mind. Then, repeat the entire measurement process and record the results on a separate Women's Measurement Form that is designated for replicate measurements. Send the separate measurement form with the replicate set of measurements to RTI with the completed interview package.

Once a month, ask clinic staff who have been trained in our procedures for height and weight to replicate your weight and height measures on the first eligible woman seen on a day that you are working in the clinic. This procedure should be arranged only in clinics where staff are using our procedures for weight and height. Clearly, this procedure should be arranged at the convenience of cooperating clinic staff.

You must also take repeat measures on the first sample child you measure each week. All measures should be taken and recorded first on the Child's Measurement Form in the Child's Interview Package. The results of the second set of measurements should be recorded on a separate Child Measurement Form that is designated for replicate measurements; the separate form should be sent to RTI with other documents completed for the child.

F. Disposition of Completed Initial Interview Documents

1. Women's Initial Interview Packages

At minimum, the following documents must be included in a complete Woman's Initial Interview:

- Screening Form (with ID label)
- Consent Form--White copy (with ID label)
- Women's Initial Interview Package (with ID label)
- Follow-up Interview Data Sheet (with ID label)

In addition, if the respondent agreed to sign the Authorization Form, it should be included, as should the Hospital Records Abstract Form you complete for the respondent.

When you have completed all Initial Interview documents, package them in the following order inside the front cover of the Initial Interview Package:

- Screening Form
- Consent Form
- Authorization Form
- Hospital Records Abstract Form
- Follow-up Interview Data Sheet
- IF USED--Continuation Section for Pregnancy and Live Birth History.

If you were not required to collect data about any of the respondent's children--no sample child 0 through 4 years old was identified--mail the package for the woman to RTI in a preaddressed, postpaid envelope. Mail only one completed case in an envelope. REPEAT, put one and only one set of completed Initial Interview documents in an envelope.

2. Children's Data Collection Instruments

If you collected data about one or more of the respondent's natural children, you must mail all documents for the woman and her child(ren) together in the same envelope.

All packages and forms for children must be placed inside the back cover of the mother's Initial Interview Package, in the following order:

- Documents for Sample Child

  (1) Consent Form--put inside front cover of Child's Interview Package

  (2) Child's Interview Package

  (3) IF CHILD IS FOUR YEARS OLD:

    (a) Answer Sheet for Picture Vocabulary Test--put inside front cover of Child's Interview Package

    (b) Behavior Inventory--put inside front cover of Child's Interview Package

- Documents for Other Four- and Five-Year-Old Children--Package documents for each child separately, in the order indicated above.

Check all documents completed for children to insure that the proper ID labels from the ACF have been used and that whenever you have written ID numbers on forms, that you entered the correct ID numbers.

Remember--completed packages for a woman and her child(ren) must be mailed in the same preaddressed, postpaid envelope.

APPENDIX IV-C. DIETARY AND ANTHROPOMETRIC METHODOLOGY

A. TRAINING IN DIETARY METHODOLOGY AND CODING OF DIET RECALLS

Precoded forms for women and preschool children were created to record the 24-Hour Dietary Recall. These forms listed foods and beverages judged on the basis of national studies (USDA Basic Nationwide Food Consumption Survey, 1977-1980, unpublished; USDA Low Income Surveys, 1977 and 1980, unpublished; HANES II, 1976-1980, unpublished) to be most often consumed by women and young children. There were 360 foods on the women's form and 422 on the children's form. Foods that were not precoded were recorded on the form and later coded at the Research Triangle Institute by dietary editors/coders.

The models used to estimate quantities of food eaten during the Dietary Recall Interview were adapted from those used in the National Health and Nutrition Examination Survey (US DHEW, 1976a) and the National Evaluation of the School Lunch Program (SDC, 1982). The models were not replicas of foods; rather, they represented portion sizes. The models included plastic discs, squares, rectangles, wedges, thickness indicators, a ruler, bowls, spoons, cups, glasses, infant jars, and an infant formula bottle.

Field operatives received 2-1/2 days of training in quantitative dietary assessment techniques. During these sessions, the purpose of the interview was reviewed, instruments were introduced, and instruction was given in general dietary interview procedures, probing techniques, use of the food models, and recording conventions. These lessons were applied in several practice sessions. During the course of the study, RTI supervisors of field activities regularly reviewed the work of the field operatives and prescribed further instruction and clarification if review indicated problems.

Editing and coding were conducted by staff with previous training in foods or nutrition who, in addition, received a 1-day training session in the editing and coding of the Dietary Recall Form. The Dietary Coding Manual developed for the WIC Evaluation was used as a guide. The editors/coders were also instructed to record specific problems on the Interviewer Dietary Problem Record. These records were used to provide feedback to the field operatives on the quality of their work and to resolve any problems with individual recalls. Initially, the project nutritionist discussed and reviewed problems of interpretation or coding with the editor/coders daily. Weekly review was adequate after the coders became more experienced.

For the first 3 months, the editor/coders recorded every tenth item they coded on the Dietary Coding Control Sheet. The coding was reviewed, and feedback was provided to the editors/coders on the appropriateness of the codes assigned. The approximately 342 foods that initially could not be assigned a code were given a temporary code. Of these foods, 207 were subsequently assigned codes from the USDA Nutrient Data Base for Individual

Surveys, 14 items were assigned codes from the USDA Standard Reference File, and 115 were permanent codes and nutrient values from manufacturers data. Two items could not be assigned codes, and the recalls in which they appeared were categorized as only partially complete. Four items were subsequently not coded because the items had no nutritional value.

RTI supervisory staff conducted ongoing quality control reviews of the work of each of the five dietary editors/coders. All items on the first 10 interviews by each coder were reviewed. Subsequently, 1 interview in every 10 was randomly recoded by another editor/coder and discrepancies resolved. The coding error rate decreased consistently from around 10 percent in the first week of coding to 1.6 to 3.4 percent in the last months of coding (RTI, 1984).

Editing of dietary recalls continued after the data were keyed. Maximum ranges of food consumption were determined from the USDA report, "Foods Commonly Eaten by Individuals" (USDA, 1975). Consumption in excess of this range was flagged. Fourteen recalls were subsequently excluded from analysis because the reported amount of a food eaten was suspect.

B. ANTHROPOMETRIC MEASUREMENTS

1. Maternal Anthropometry

Standard measuring procedures used in this study are described in Hanes II Examination Staff Procedures Manual for the Health and Nutrition Examination Survey, 1976-1979 (USDHEW, 1976) and in "Basic Data on Anthropometric Measurements and Angular Measurements of the Hip and Knee Joints for Selected Age Groups, 1-74 Years of Age" (USDHHS, 1981). Measurement procedures were also described in training and reference manuals developed in conjunction with Drs. Alex Roche, John Himes, and Francis Johnston (RTI/NYSRF, 1983).

RTI field operatives were responsible for all maternal anthropometric measurements whenever possible. Clinic staff were instructed in standard measurement procedures. Weight and height were abstracted from clinic records when RTI field operatives were unavailable or when clinic rules did not allow RTI staff measurement of women's weight or height (see Table IV-C-1, precentage abstracted). Arm circumference and skinfold thickness were always measured by RTI field operatives, never by clinic staff.

Weight

Weight was measured on beam balance scales to the finest graduation possible, usually to the nearest 0.25 lb or 0.10 kg. FNS donated Detecto beam balance scales (models 339 and 047) to clinics not possessing them.

Women were weighed standing on the scale platform with their weight evenly distributed on both feet. Whenever possible, they were weighed in clinic gowns and paper slippers (0.7 percent at Initial and Followup Interviews). Most women were weighed in light street clothing (89.4 percent at

Table IV-C-1

Percentage of Maternal Anthropometric Measurements Taken by RTI Field Operatives and Those Abstracted from Clinic Records

	Percentage of measurements (n)		
	RTI field operations	Abstracted	Not specified
Initial weight	66.1 (4,297)	32.6 (2,123)	1.3 (85)
Followup weight	70.3 (3,466)	26.3 (1,283)	3.6 (178)
Height	77.5 (5,053)	20.6 (1,342)	1.9 (127)

Initial and 96.3 percent at Followup Interviews), without shoes, sweaters, or heavy jewelry. A few women refused to disrobe at all and were weighed in heavier clothing (1.7 percent at Initial and 2.8 percent at Followup Interviews, respectively. Scales were balanced at zero prior to weighing each study participant. State inspectors of weights and measures tested and recorded the accuracy of 109 (50.2 percent) study clinic scales.

Arm Circumference

Arm circumference was measured with insertion tape devices provided by Ross Laboratories. Arm circumference was measured by locating and marking the midpoint of the left upper arm between the upper edge of the acromion process and the olecranon process of the ulna, then snugly fitting the tape immediately below the midpoint mark perpendicular to the long axis of the arm and parallel to the floor. It was recorded to the nearest millimeter.

Triceps and Subscapular Skinfold Thickness

Triceps and subscapular skinfold thicknesses were measured to the nearest half millimeter by using Lange calipers. Triceps skinfold measurements were taken by grasping the skin and subcutaneous tissue firmly with the thumb and forefinger of the left hand about 1 cm above the left arm midpoint, drawing this fold directly back from the body, confirming that the muscle tissue was excluded, applying the calipers directly over the triceps muscle with the crest of the fold parallel to the long axis of the arm, and reading the measurement after 2 to 3 seconds. The pinch was released and the process repeated for additional measurements.

Subscapular skinfold measurements were taken by palpating the inferior angle of the left scapula, grasping a fold of skin and subcutaneous tissues with the thumb and forefinger of the left hand directly above the angle, parallel to the natural cleavage lines of the skin, drawing the fold straight back from the body, confirming that muscle was excluded from the fold, applying the calipers with the right hand about 1 cm below the thumb and forefinger, and reading the measurement after 2 to 3 seconds. The pinch was released and the process repeated for further measurements.

The mean of two skinfold measurements at each site was used. If three measurements were taken (obligated if the first two differed by more than 3.0 mm) the mean of the third and the other measurement closest to the third was T_x = 2.7 percent, T_2 = 2.6 percent). If only one skinfold was available for that site (T_2 = 1.2 percent, T_2 = 1.7 percent), it was accepted.

Replicate Measurements

For the first study-eligible woman measured each week, data collectors repeated the entire measurement procedure after completing initial measurements. The initial and replicate measurements were taken by the same staff member except once a month, when clinic staff trained in these measurement procedures took replicate height and weight measurements. Replicate measurements were taken to estimate the reliability of our anthropometric data. The correlation coefficients between original and replicate measurements are presented in Table IV-C-2.

Training Field Operatives in Anthropometric Techniques

Approximately one half day was dedicated to training from 15 to 25 field operatives simultaneously in techniques for anthropometric measures in women. Each operative practiced the techniques on at least two other data collectors and was required to take and record two triceps and subscapular skinfold measurements on an anthropometric trainer. Operatives judged to require more training received further one-to-one instruction. Replicate measurements were reviewed soon after the start of data collection; further training was provided by field supervisors when review of replicate measurements suggested problems.

Review of Outlier, Corrections, and Exclusions

All measurements for a woman were reviewed for coherence and likelihood of error by study staff if the woman's weight was below 80 lb or above 275 lb at Initial Interview or above 300 lb at Followup Interview, if height was below 54 or above 78 in., if arm circumference was below 13.9 or above 46.9 cm at Initial Interview or 49.9 cm at Followup Interview, if triceps skinfold was below 4.0 or above 60.0 mm, and if subscapular skinfold was below 2.5 or above 55.0 mm. Obvious keying errors were corrected (inches coded as centimeters, misplaced decimal points). Some values were too extreme to be biologically plausible, but could not be corrected, and were therefore excluded from analyses.

Table IV-C-2

Intra- and Inter-Observer Measurement Reliability as Estimated by Correlation of Original and Replicate Measurements for Women at Initial and Followup Interviews

	Intra-observer correlation coefficient		Inter-observer correlation coefficient	
	At Initial Interview	At Followup Interview	At Initial Interview	At Followup Interview
Weight (kg)	0.9997	0.93665	0.93060	-
Height (cm)	0.98082	-	0.99466	-
Arm circumference (cm)	0.97141	0.90239	-	-
Mean triceps skinfold (mm)	0.99500	0.69999		
Mean subscapular skinfold (mm)	0.99544	0.70295	-	-

2. Child Anthropometry

Standard weighing and measuring procedures used in this study are described in "A Guide to Pediatric Weighing and Measuring" (USDHEW, 1981) and in "HANES II Examination Staff Procedures Manual for the Health and Nutrition Examination Survey, 1976-79" (USDHEW, 1976a). Measurement procedures have been described previously in "The National WIC Evaluation: A Study of Health and Nutrition of Mothers and Their Children, Field Procedures Manual" (RTI/NYSRF, 1983).

Weight

Children were weighed nude if under 2 years of age and in underpants if older. Children too young to stand unaided on the scale platform were weighed recumbent or sitting on the center of the platform. Older children stood in the middle of the scale platform with their weight evenly distributed on both feet. Scales were balanced at zero prior to weighing each child. Recalibration of scales was not necessary during the study, since scales were rarely used to weigh more than 30 children over the entire study period.

Weight was measured to the nearest ounce on new Chatillon PBB 131X beam balance scales accurate to 0.25 oz. and remeasured for those whose weight for stature was less than the 10th or greater than the 90th percentile of the NCHS reference standards (USDHEW, 1976).

Stature

Recumbent length was measured in infants and young children; standing height was measured in children older than 2 years who could stand erect unaided with standardized posture. Length/height was measured with minimal clothing and without shoes or socks by using a device which incorporated the designs of traditional length boards and portable stadiometers to facilitate either measurement.

Two people measured length on a table or other flat surface available in the child's home. One person, often the mother, held the infant's head vertically, with the crown of the head placed firmly against the attached headboard. The data collector aligned the infant's trunk and pelvis with the measuring device, straightened the infant's legs, held the feet together with toes pointed directly upwards, guided the foot block up against the measuring stick until firmly against the feet, and read the measurement. Standing height was measured with the attached footboard of the device placed flush against a wall. Children were told to stand erect with their back, heels, and head against the wall with their feet at a 45 degree angle and their heads positioned in the Frankfort horizontal plane. Stature was measured to the nearest millimeter and was remeasured if weight for stature was greater than the 10th or less than the 90th percentile of NCHS reference data (USDHEW, 1976b).

Head and Arm Circumference

Head and arm circumference were measured with a disposable, laminated, paper insertion tape device and recorded to the nearest millimeter. Head circumference was measured sitting or standing, with the lower edge of the tape positioned just above the eyebrows and ears and over the maximum occipital prominence. It was noted if hairstyle interfered with the measurement. Arm circumference for children was measured in the same way as described above for women.

Skinfold Thickness

Triceps and subscapular skinfold thickness measurements were taken in the same manner as described for women.

Replicate Measurements

For the first child measured each week, data collectors repeated the entire measurement procedure after completing initial measurements. The initial and replicate measurements were taken by the same staff member, because only one data collector could be sent to each household. Replicate measurements were taken to estimate the reliability of our anthropometric data. The correlation coefficients (r) between original and replicate measurements are as follows: weight, $r = 0.97$; standing height, $r > 0.99$; recumbent length, $r < 0.99$; head circumference, $r = 0.99$; arm circumference, $r = 0.98$; triceps skinfold, $r = 0.96$, and subscapular skinfold, $r = 0.95$. These very high values may not be valid and could reflect the expectation of field operatives that they were required to get exact replicative measurements.